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Here see p. 37 and 55.



The First
Annual Report
of the
Orient Hospital



BEIRUT, LEBANON
1948

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*Foreword
to the
Medical Profession in general
and to our
Clients and Friends in particular*

*This
First Annual Report
of the
Orient Hospital
is presented*

*by the founder
S. J. H.*

*The Story of its Foundation and the
Record of the First Year's Work.*



OCTOBER — 1948
BEIRUT, LEBANESE REPUBLIC

قرار رقم ١١٢٧

ان وزير الصحة والأسعاف العام
بناء على المرسوم رقم ٧٦٨٦ تاريخ ١٤/١٢/٩٤٦
بناء على القرار رقم ٢٥٢٢ تاريخ ٢٣/٦/٩٤٦
بناء على طلب الدكتور سامي حداد باستثمار مستشفى للجراحة العمومية
والأمراض الداخلية في محلة ميسناة بحسن شارع منسيور شبلي
وبعد الاطلاع على الخرائط المقترحة
وبناء على اقتراح مدير الصحة والأسعاف العام

يقرر ما يأتي =

المادة الأولى - رخص للدكتور سامي حداد باستثمار مستشفى للجراحة العمومية والأمراض الداخلية في محلة ميسناة بحسن شارع منسيور شبلي بيروت

المادة الثانية - يتوجب على الطبيب المذكور التقيد بالشروط المنصوص عليها في القرار رقم ٢٥٢٢ تاريخ ٢٣ حزيران سنة ١٩٤٦ وبالشروط المخافة الآتية =

- ١ - وضع نسيج معدني على النوافذ منعا لدخول الذباب والبعوض
- ٢ - عدم قبول امراض سارية
- ٣ - تفريق الأسرة بنوع ان يكون لكل مريض لا يقل عن ٢٥ مترا مكعبا من الهواء

المادة الثالثة - يبلغ هذا القرار حيث تم عواكبه الى ذلك .

بيروت في ٢٥ كانون الثاني ١٩٤٧

الأعضاء : الدكتور الياس الخوري

نور الدين بن

ببلغ الب
محافظة بيروت
صاحب العلاقة



THE ORIENT HOSPITAL

Haouz Saatieh, Beirut
Lebanese Republic

In the city of Beirut, the Berytus of the ancient Phœnicians and the capital of the Lebanese Republic, the Orient Hospital was erected a year ago to-day.

Beirut, situated at a very strategic point on the Mediterranean littoral, is the gate of the East and the connecting link between the East and the West. The city wherefrom the light of the ancient civilizations of the East were transmitted to the West, welcomes to-day the civilization and culture of the West and blends them with those of the East to form a world civilization working towards the "Common Cause".

Beirut promises to become a great metropolis. Its modern sea-port facilities ; its new areodrome, which is only a few kilometres from the heart of the city ; its close proximity to the Lebanon Mountains which provide it with excellent summer resorts, and ample facilities for winter sports ; and above all, its mild salubrious climate which has proven to be one of the best in the world for pulmonary and allied diseases, contribute towards making Beirut a very attractive city to the Easterns as well as to the Westerns.

In the very heart of this city the Orient Hospital stands to - day. Situated on a slight elevation it has command of a very picturesque and attractive panorama. It overlooks the entire city, the bay of Saint George, and the Lebanon chain of mountains, with Sannin, its snow-capped peak in the background.



The Hospital is very easy of access. It is only a few yards from the main tramway line which links the centre of the city with the Damascus Road and Ras Beirut, and although located in a very busy section of the city, it seems to stand aloof from the street turmoil and traffic, thanks to the spacious garden which adds to the attractiveness of the hospital and gives it the privacy and calm which are highly appreciated by the patient.

HISTORY

The site on which the hospital stands to-day was appropriated for the purpose twenty-two years ago, but, for certain reasons this dream was not realized until this past year.

During these 22 years the place has been used for different purposes and has undergone many changes. It was occupied by the Italian Consulate when it was bought. A little over a year later it was converted into an Italian school for girls. Finally the French Army used it as a bureau for the Army Intendence.

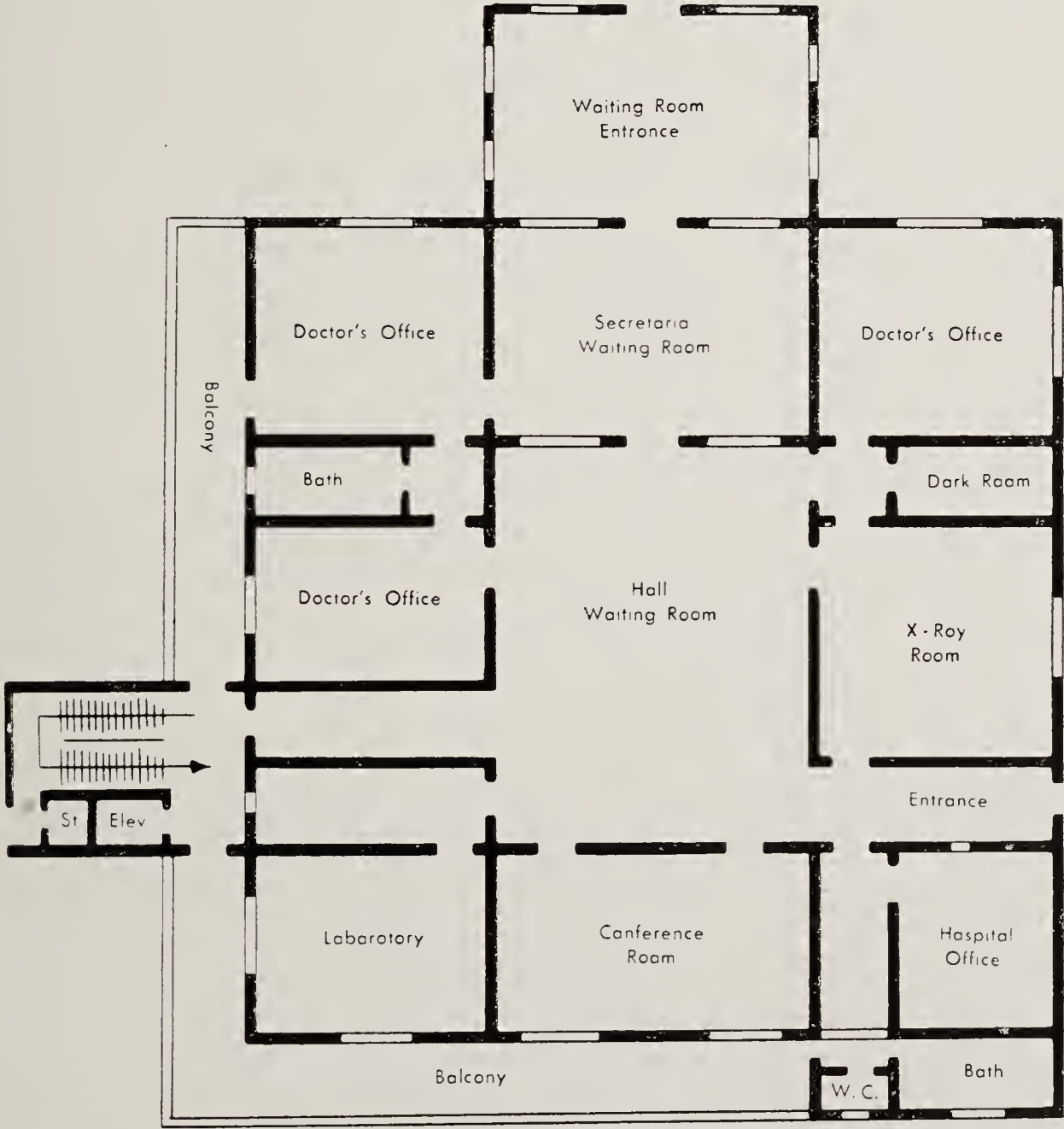
In August of the year 1946 the army evacuated it, and it was not until after over one year's work of reconstruction and repairs that it was ready to be used for the hospital.

Substantial changes had to be effected in the main building and a new wing of two stories was added.

THE HOSPITAL PLAN

The hospital as it stands to - day consists of a central building and two wings, the east and the west wing.

The central building consists of 5 floors. The first floor contains the administration offices, the doctors' offices, the X-ray department, the laboratories, the staff room and three spacious waiting rooms.



FIRST FLOOR

The second floor has a central hall, around which there are 4 private rooms, 4 semi-private rooms and the nursery. The north end of this floor is reserved for the maternity cases and the rest of the space is reserved for the female patients of the different services.

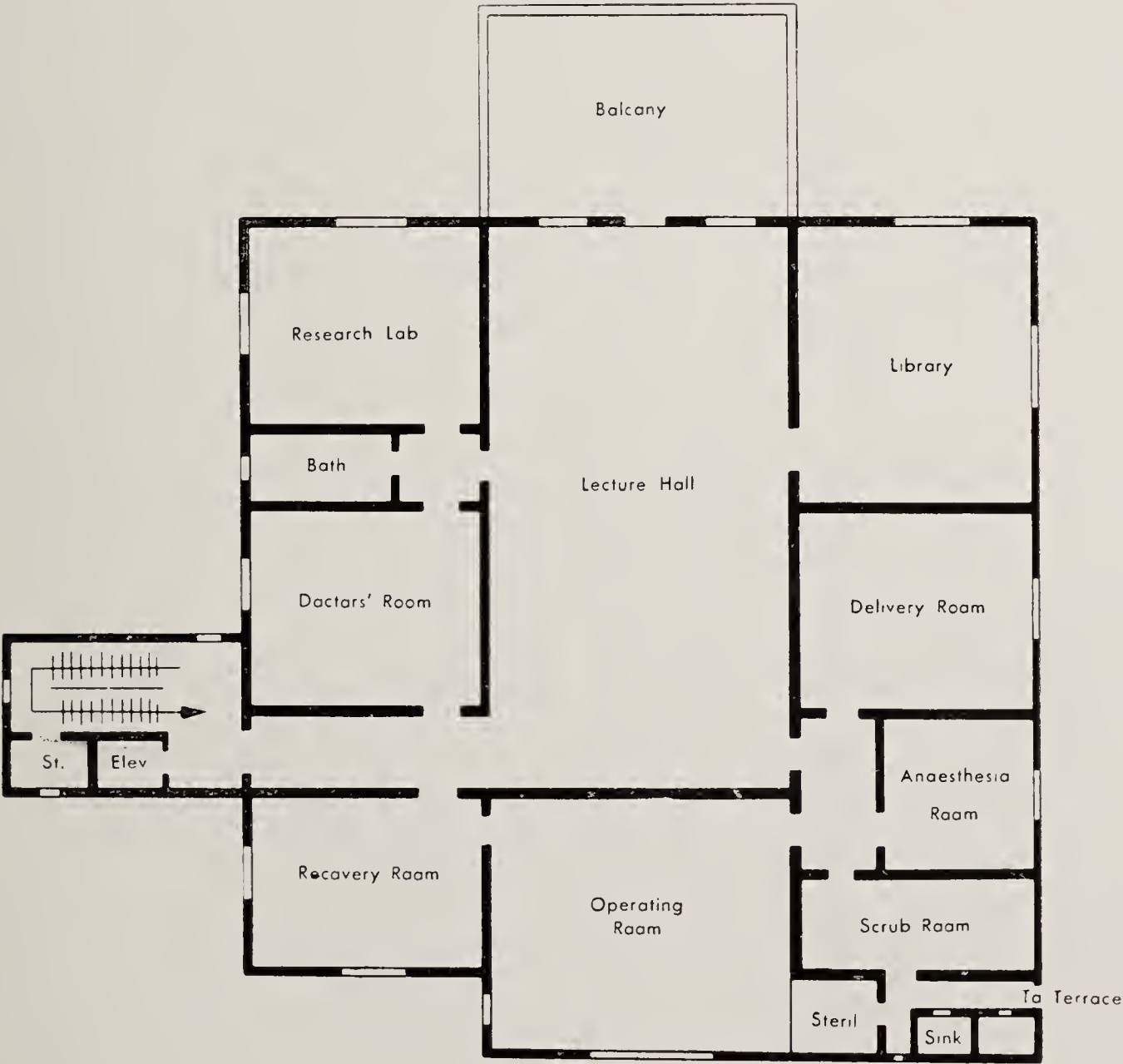
The third floor is similar in its arrangement to the second floor and is for the male patients.



SECOND FLOOR

The fourth floor is reserved for the operating room suit which includes the anæsthesia room and the recovery room ; the delivery suit ; the library ; the research laboratory and a spacious lecture hall.

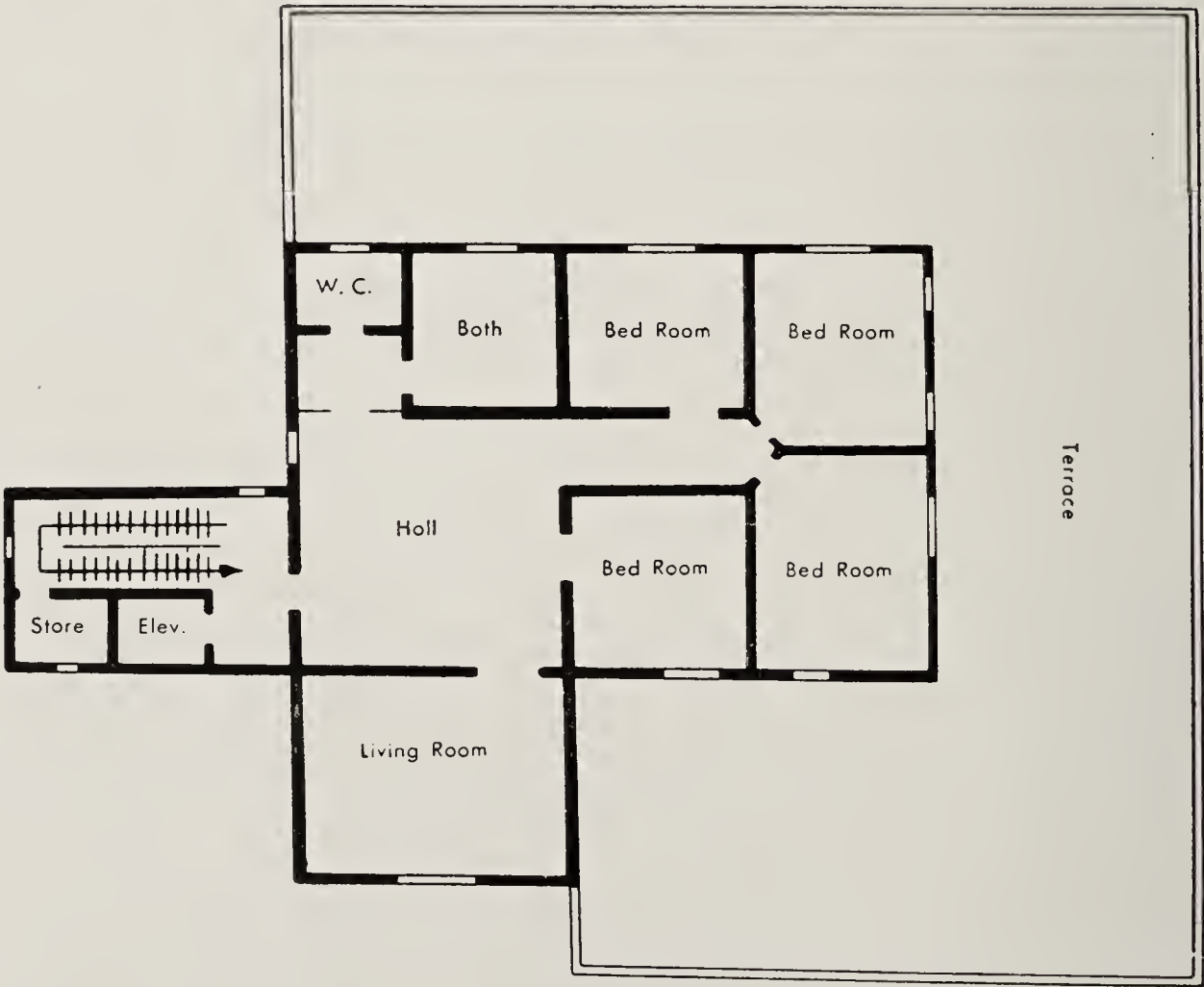
The fifth floor is for the resident staff. There are 5 bed-rooms with their bath - room facilities and a sitting room. All is surrounded by a roof garden where from one can have a beautiful view of the whole city.



FOURTH FLOOR

The east wing has 3 floors and a basement. The basement houses the furnace, the laundry, the autopsy rooms and the morgue. The first floor contains the free clinic. The second floor provides space for 15 third class and charity beds. The third floor contains the kitchen and dining rooms.

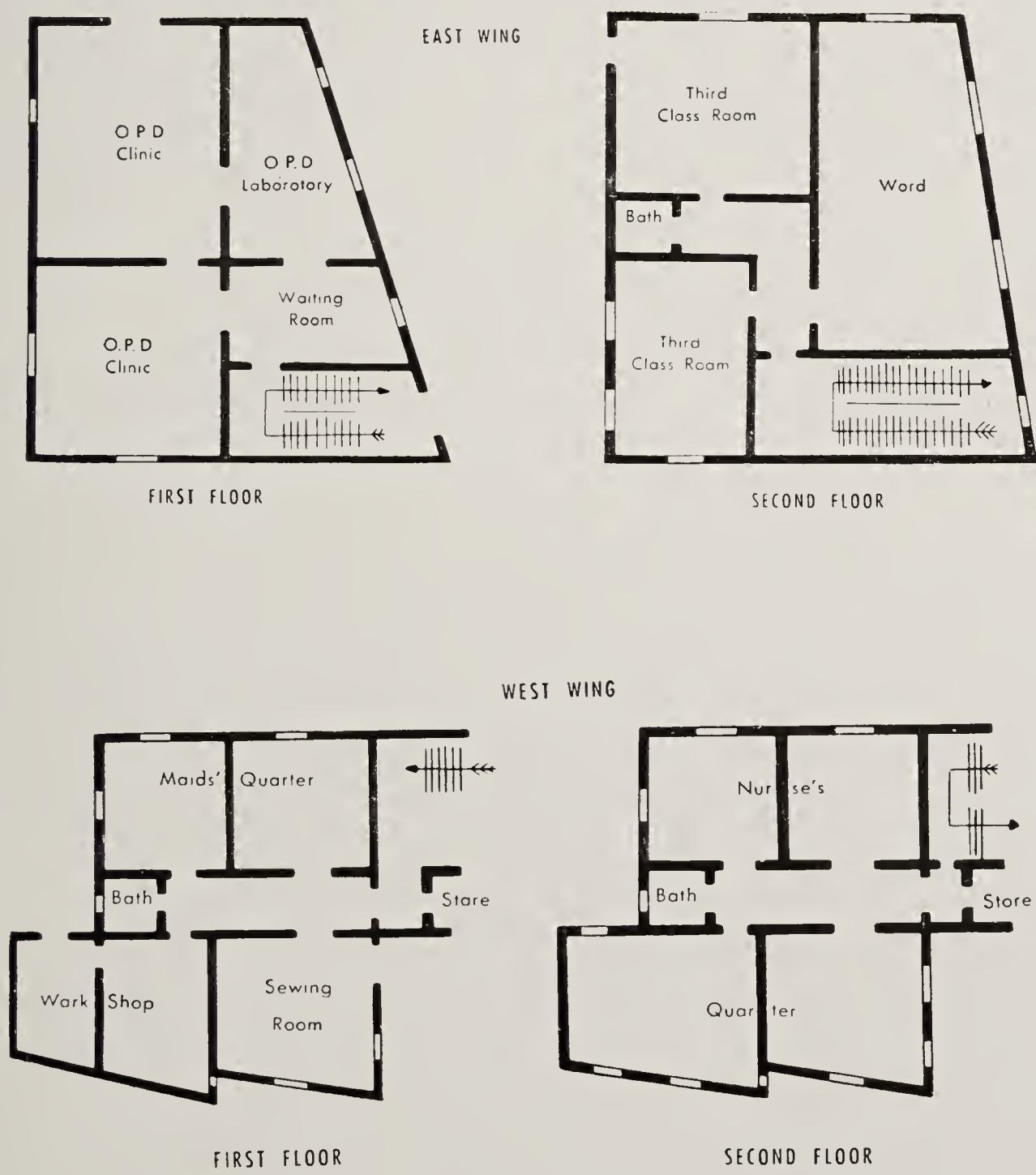
The west wing has 2 floors ; the first provides living quarters for the maids, a sewing room and a work shop. The second floor is for the hospital personnel.



INTERNES QUARTER

The total number of beds is 50, besides the 6 cots in the nursery. There are 8 private, 22 semi-private, 15 third class and charity beds, 3 recovery and 2 isolation beds.

The temperature in the nursery is kept constant by means of an automatic electric heater and ventilator.



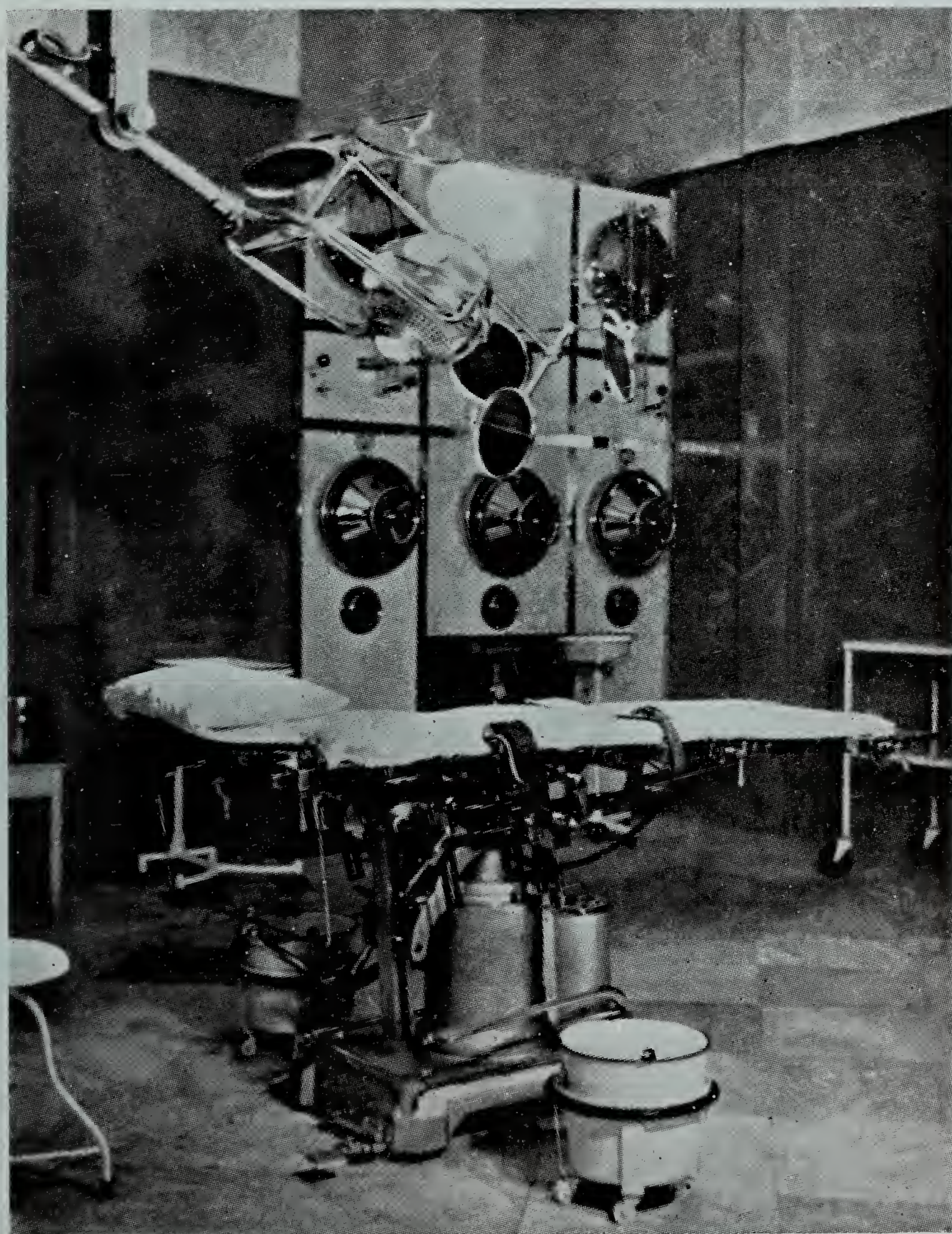
The private and semi-private beds are of the most modern type of mechanical hospital beds and the mattresses are of the best kind of beauty-rest inner-spring mattresses. To each bed there is an all-metal over-bed and a bed-side table with rubberized lenolium tops. The modern bed-lamp N° 45, recently devised by Mr. Hall of "Frank Hall & Co" of New York is attached to each bed, adding to the patient's convenience.

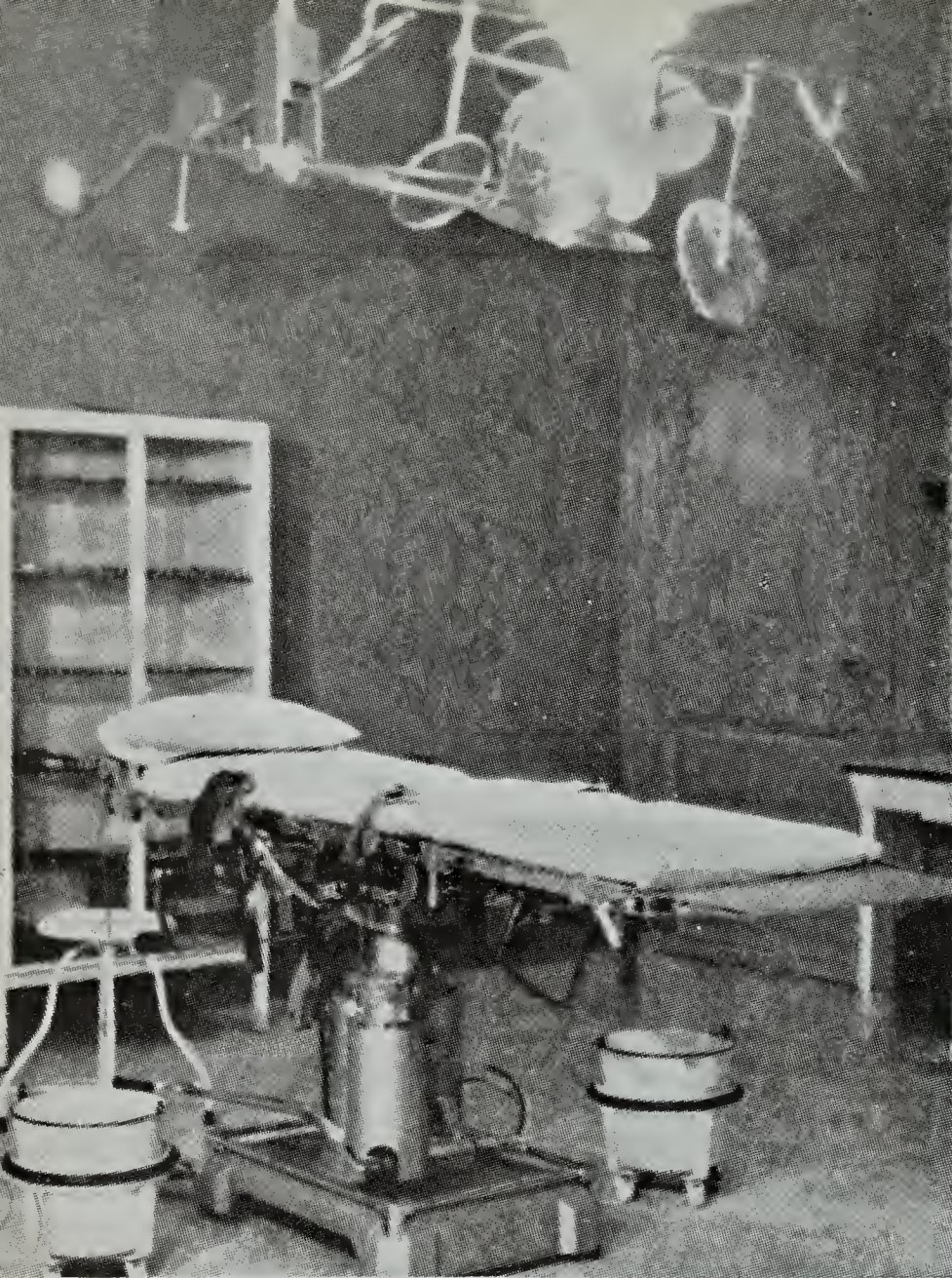
The third class and charity beds are of the best type of hospital beds and every ward is provided with a mechanical bed, to be used for patients who may be in need of it.

All the patients' rooms have a system of running cold and hot water. Solaria are abundant and give an invigorating spark to the whole atmosphere.



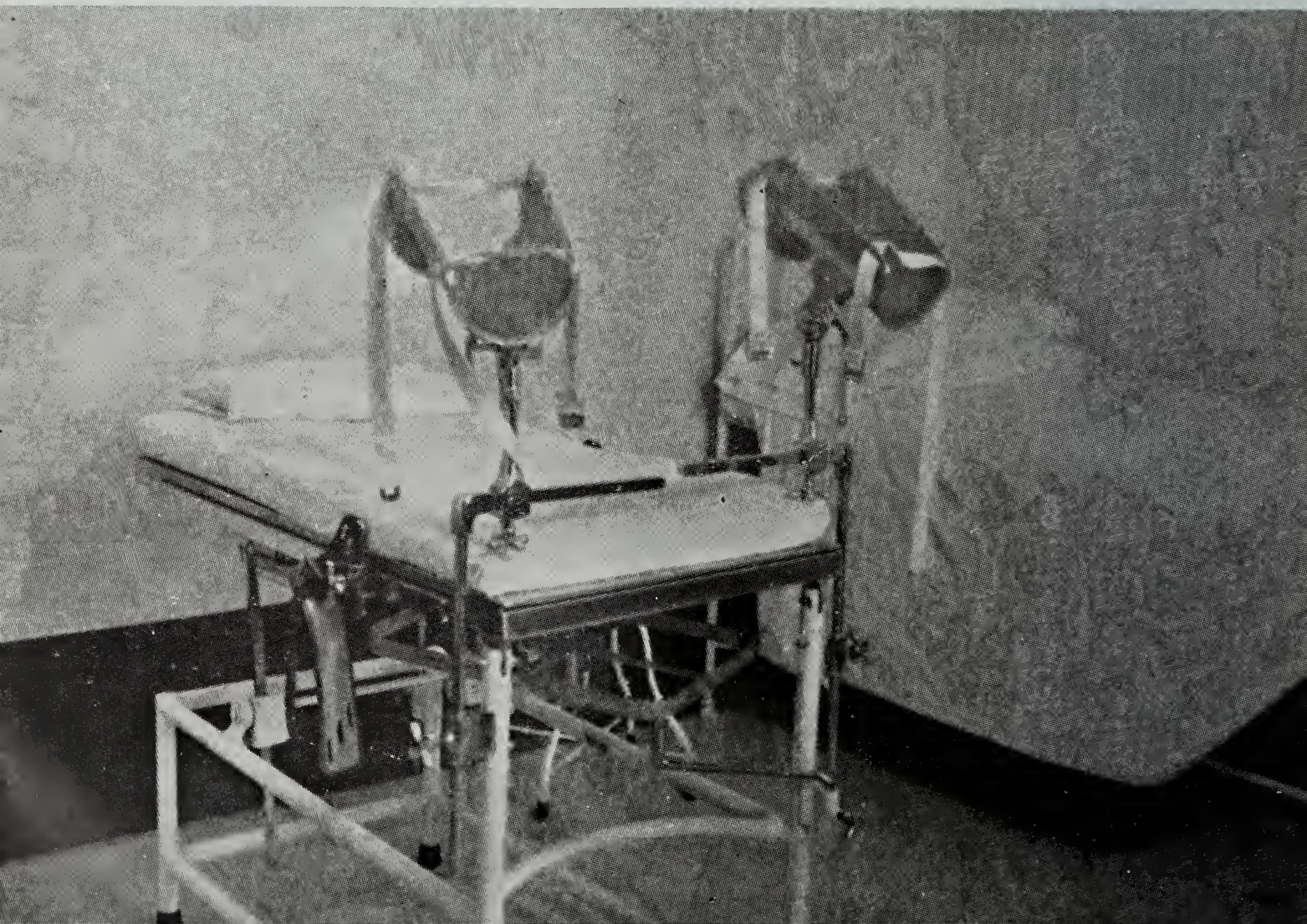
The operating room is provided with a sterilizing unit of the most modern type. It consists of a steam heated, recessed battery of three dressing and 2 water sterilizers and an electric oven for sterilizing cutting edge instruments.





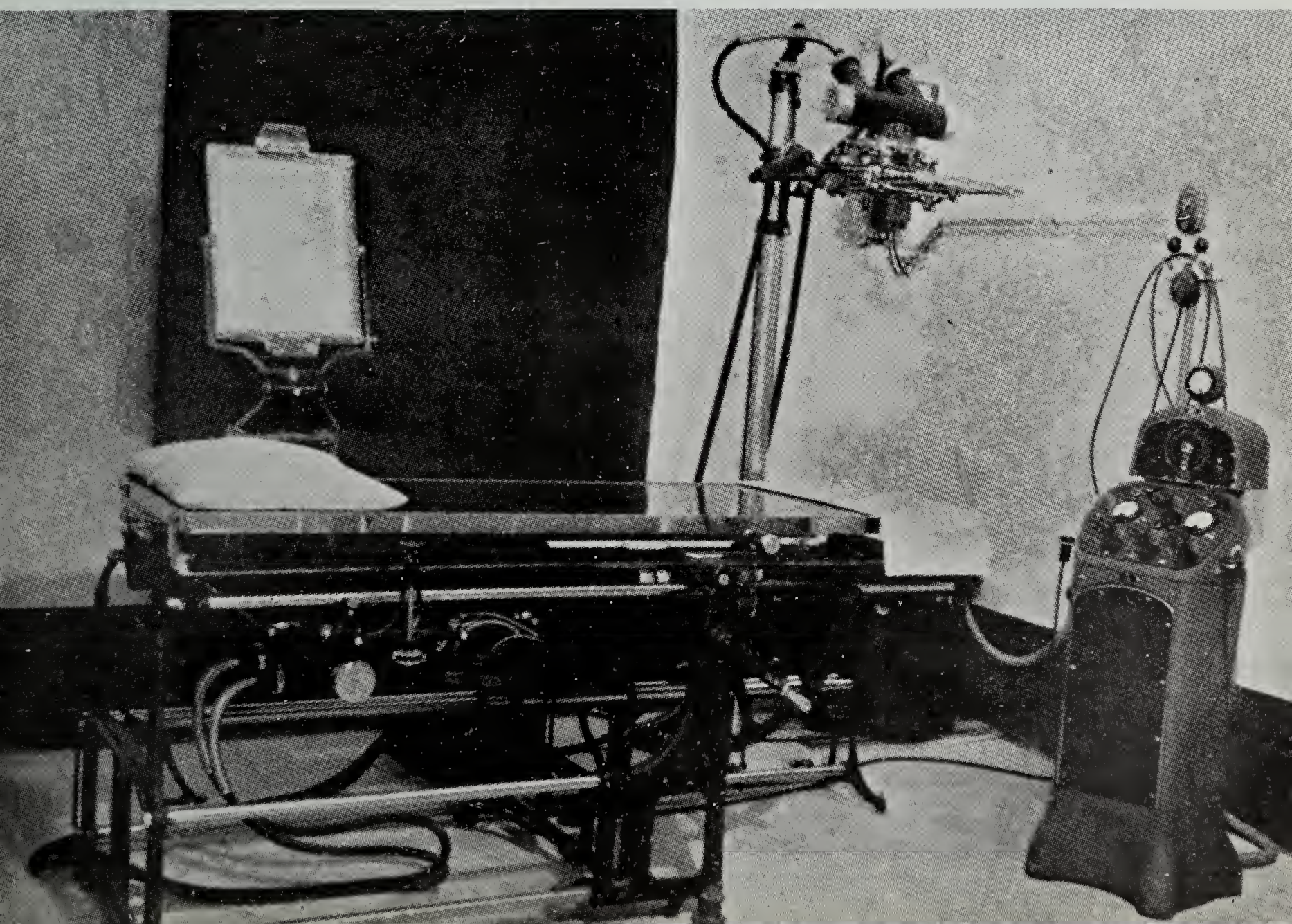
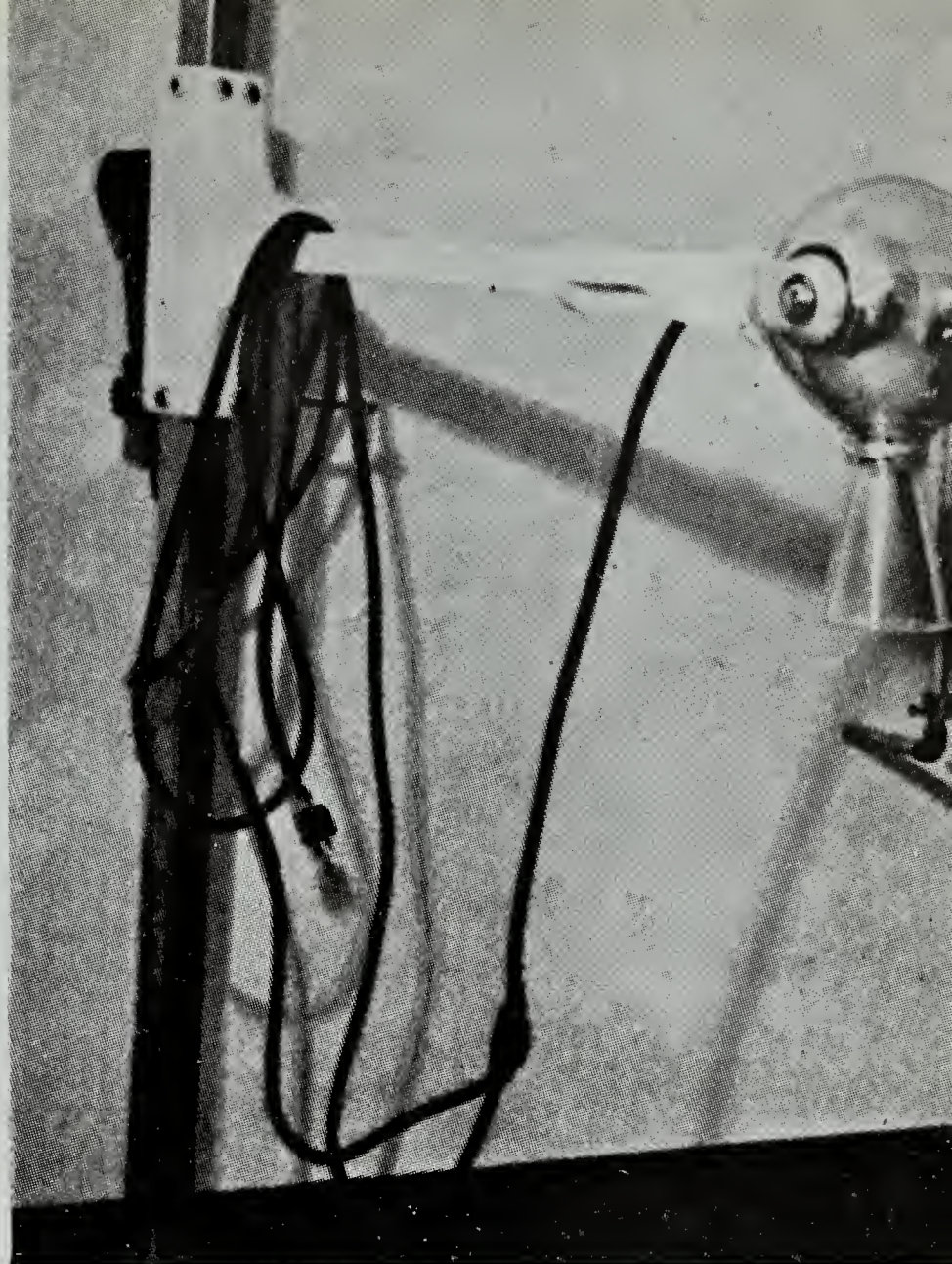
The operating table is of the Scanlan - Morris type, over which there is an operty multibeam projection lamp, and on the floor there is a Castile self-contained emergency light. The equipment in the operating room is adequate for the performance of all major operations in surgery and the surgical specialities.

The delivery suit is equipped with a delivery table similar to that used in the women's hospital in the city of New York. A complete outfit of instruments is available to take care of any emergency that may arise in the course of a delivery.



The department of Roentgenology and Electrotherapy is equipped with the most modern type of machinery and apparatus. The big X-ray unit gives 200 milliamperes and allows for screen work and for taking excellent films for diagnosis. The mobile Sanitas machine is very useful for handling emergency cases and work at the bedside. The portable machine, "the Heliosphere" is very useful in the operating room and for taking pictures in the patient's own home.

The ultra-violet unit, infra-red lamp and diathermy and short wave machines are of the most modern types.



The library contains two thousand volumes of medical books and journals and receives 25 medical periodicals in Arabic, English and French.

The laboratory is well equipped and can take care of all the routine examinations required for diagnosis. The blood-chemistry is done with the aid of the "Lumetrom Photo-electric Colorimeter" and the "Klett Colorimeter". A Spencer hemoglobino-meter and many other types of apparatus are in daily use. Facilities for making cultures of blood, urine, stools and other serological studies are provided for.

The research laboratory on the fourth floor is close to the library and has all the facilities for preparing histo-pathological specimens. All the specimens from the operating room are carefully preserved and kept for further study and reference.



The lecture hall on the fourth floor accomodates 200 persons and is long enough to allow for the projection of moving pictures and lantern slides.

An intra-mural phone system is installed in the hospital. This greatly facilitates the smooth running of the work by providing a ready means of communication between the different hospital sections.

Extension of the city phone to the private rooms is a very highly desirable convenience which is greatly appreciated both by the patient and his family.

A complete patients' record system is kept in the hospital. Every patient has his record carefully kept. The patients' names are filed in alphabetic order, and a special filing system is adopted for diagnosis.



EQUIPMENT AND SUPPLIES

In June of the year 1947, Dr SAMI HADDAD left for the United States where he joined Dr MUSTAFA KHALIDY and they both spent a long time purchasing



DRS. MUSTAFA KHALIDY & SAMI HADDAD
IN ATLANTIC CITY, ATTENDING
THE AMERICAN MEDICAL ASSOCIATION CENTENNIAL

furniture and equipment for the hospital. Many friends helped a great deal by their advice and sympathy and to all of them a debt of gratitude is due.

Many difficulties were encountered and had to be overcome. Most important of which was finding foreign currency for the purchase of the equipment. We had to resort to the black market for the mighty dollar.

On September of the same year the supplies began to arrive in Beirut, and it was a big job clearing them through customs. We owe our son Dr FARID S. HADDAD a great deal for the trouble he took in seeing this job through. We had to pay duty on every item that passed through customs, even the surgical instruments and the laboratory equipment was not exempted.



A brighter aspect of the problem of purchases, however, is the help which one man has given to ease up our difficulties. The zeal, energy and devotion which this friend has shown are highly commendable. Dr MUSTAFA KHALIDY's name will always be remembered with gratitude and admiration as long as the Orient Hospital exists.

We were back in Beirut on the third of September but it was not until one month later that we were able to start work.

FINANCES

The question of the finances of any private institution is a very delicate subject to discuss and one which may not appeal to the general public. Suffice it to say that this institution is financed entirely by the founder, and that it has not received at any time any financial assistance of any kind from any private person, nor has it received any subsidy from any government, institution or any other organization.

GOVERNMENT LICENCES AND ORDINANCES

The hospital is operating under a licence from the Ministry of Health and Public Assistance. It was registered under the name "The Orient Hospital" on the sixteenth of September 1947, and on the first of April 1948 the Ministry of Health issued an ordinance recognizing it as a training institution for internes in medicine.

الجمهورية اللبنانية

عدد ١٩٤٥

حضرة الدكتور سامي حنّاد المحترم

جواباً على كتابكم تاريخ ١٠ ايجاري بشأن تسيمة مستشفاكم
المرخص باستثماره بموجب قرار رقم ١١٢٧ تاريخ
٢٥ / ١ / ٩٤٧ باسم مستشفى الشرق ، تشرفت
باعلامكم بان هذه الوزارة قد اخذت علماً بالأمر
وارسلت للدائرة المختصة صورة عن هذا الكتاب
تدليلاً لموافقتها . وقبلوا الاحترام .

بيروت في ١٦ ايلول ١٩٤٧
وزير الصحة والسكان العام

كتبه نور الدين زين

الجمهورية اللبنانية

عدد ٥٠٩

حضرة الدكتور سامي الحداد ، صاحب مستشفى
الشرق في بيروت المحترم

بناءً على الكشف الذي أجرى في مستشفىكم المجهز
بالأدوات الحديثة الكاملة ،

لذلك فإن هذه الوزارة قررت اعتبار مستشفىكم
من المستشفيات التي يحق لها ان تأخذ تلامذة الطب
في سنتهم النهائية التمرينية ، التي تؤهلهم للمسؤول
البلغة الفاحصة للحصول على اجازة ممارسته مهنة الطب
في لبنان وتفضلوا بقبول الاحترام .

بيروت في ايمان ١٩٤٨
وزير الصحة والاسكان العام

كتبه نور الدين زين

بلغ
نفاذ الاطباء
الجامعة الاميركية - المعهد الطبي -
المعهد الطبي الفرنسي
صاحب الامانة
مكتب المرافقة

PLANS FOR FUTURE DEVELOPMENTS

This is not the time to brag about plans for future developments, but we would like to state briefly that we hope it will be possible in the very near future to hold conferences and seminars on important medical subjects in the hospital ; that we will soon be ready to give advanced training in medicine, surgery, obstetrics, gynecology and X-ray ; that our research laboratory will be a nucleus around which a greater national laboratory may be developed and that a school of nursing will become affiliated to the hospital.

All we ask from our friends is their sympathy and forbearance.



THE HOSPITAL STAFF

HADDAD, SAMI I. M. D., F. A. C. S.	Surgery.
KHALIDY, MUSTAFA M. M. D.	Gynecology and Obstetrics.
HADDAD, ZAHY I. M. B. E., M. D.	Roentgenology & Electro - therapy.
SAAD, NAJIB M. D.	Eye, Ear, Nose and Throat.
OBEID, JABRA A. M. D.	Internal Medicine.
NASSAR, MAURICE G. M. D.	Internal Medicine.
MANASSAH, PHILIP S. M. D.	Internal Medicine.
YERETSIAN, KHOREN K. H. B. A., M. D.	Cardiology.
KHALAF, HABIB N. M. D.	Internal Medicine.
GHATTAS, JOSEPH M. D.	Cardiology.
MALOUF, ADIB M. D.	Pediatrics.
YENIKOMSHIAN, VAHRAM M. D.	Pediatrics.
HADDAD, CEDRIC A. D. D. S.	Dentistry.

ELIA, FOUAD M. D.	Resident.
ABDOUSH, NICOLAS J. B. ès Sc., M. D.	Resident.
ATAWNEH, ALI F. B. A., M. D.	Interne.
HADDAD, FOUAD S. B. ès Sc., B. A., M. D.	Interne.
HARONIAN, CAMILLE B. ès Sc.	Interne.

*The following doctors were attached to the Hospital as
5th. year students before they were graduated.*

ATAWNEH, ALI F. B. A., M. D.
BUSTANI, NAMAN M. D.
HADDAD, FARID S. B. ès Sc. & L., B. A., M. D.
JARRAH, JAMAL M. D.

ADMINISTRATION

HADDAD, SAMI I.

KHALIDY, MUSTAFA M.

HADDAD, ZAH I.

Superintendant.

Medical and Technical Adviser.

Business manager.

BASHA, ALEXI

KHATER, ALPHONSE

Book keeper.

Purchaser.

BARDAKJIAN, STELLA

BARDAKJIAN, MARY

HADDAD, MATILD

Matron and House - keeper.

Operating - room Nurse.

Nurses Supervisor

Out - patient Department In charge of the Palestinian Refugees

HADDAD, ZAH I. M. B. E., M. D. Director general.

KHOURI, HANNA N. B. A., M. D.

NASR, WADIE B. A., M. D.

HADDAD, CHAFIC M. D., D. T. M.



BIOGRAPHY OF THE HOSPITAL STAFF

HADDAD, Sami I., b. 1890,
M. D. 1913, A. U. B.,
F. A. C. S. 1934,
A. U. B. staff 1914 - 1932,
A. U. B. faculty 1932 -
Emeritus Professor of Surgery

HADDAD, Zahi I., b. 1895,
M. D. 1918, A. U. B.,
M. B. E. 1923,
Sen. Med. Off. Pales. Railways 1920,
Sen. Med. Off. Pales. Gov. 1937.

SAAD, Najib, b. 1892,
M. D. 1918, A. U. B.,
A. U. B. staff 1925 - 1928,
A. U. B. faculty 1928.

KHALIDY, Mustafa M., b. 1895.
M. D. 1920, A. U. B.,
A. U. B. staff 1920 - 1925,
A. U. B. faculty 1925 - 1947,
Clinical Professor of Gyn. & Obst.

OBEID, Jabra A., b. 1897
M. D. 1922, A. U. B.,
A. U. B. Lecturer in Phys. '22-'23
Private Practice, Beirut.

NASSAR, Maurice G., b. 1913,
M. D. 1937, A. U. B.,
Resident A. U. B. Hosp. 1937 - 1939.
Physician St. Georges Hosp. 1937-1942,
Director St. Georges Hosp. 1947 -
Private Practice, Beirut.

HADDAD, Cedric A., b. 1907,
D. D. S. 1928 A. U. B.,
A. U. B. Inst. Dental Surg. 1930-1939,
A. U. B. Consult. Dental Surgeon.

YERETSIAN, Khoren K. H., b. 1904
B. A. 1927, A. U. B.
M. D. 1931, A. U. B.
A. U. B. Cl. Assist. 1931 - 1936
Dept. of Health, Beirut.

MANASSAH, Philip S., b. 1910
M. D. 1932, A. U. B.,
Superintendent Friends' Hosp. '36-'40
Private Practice, Beirut.

MALOUF, Adib, b. 1914,
M. D. 1937, A. U. B.,
Director General of Health, Beirut,
First Grade.

NASR, Wadie, b. 1893,
B. A. 1910, A. U. B.,
M. D. 1915, A. U. B.,
Secretary Med. Assoc., Haifa,
Private Practice, Haifa, Palestine.

KHOURI, Hanna N., b. 1895
B. A. 1911, A. U. B.,
M. D. 1920, A. U. B.,
Private Practice, Haifa, Palestine.

HADDAD, Chafic, b. 1910
M. D. 1934, A. U. B.,
D. T. M. 1939, London,
Internist, Gov. Hosp., Haifa, Pales.

KHALAF, Habib N., b. 1904
M. D. 1932, Nancy (with honours)
Lung Diseases, Sanat. Villemin, Nancy.

GHATTAS, Joseph, b. 1915,
M. D. 1939, A. U. B.
Private Practice, Beirut, Lebanon.

The First Annual Medical Report of the Orient Hospital

The Orient Hospital opened its doors for patients on the first day of October 1947. During the year patients of every creed, nationality and social standing were hospitalized. Government ministers and officials, prelates and heads of churches, nobles and laymen were attended to and treated with equal care and devotion.

The Out-patient Department

The out-patient department was very active throughout the year. One thousand one hundred and twenty-one patients were examined and treated free of charge. The Palestinian plight considerably increased the load on this department and we had to call for extra help. Dr. HANNA KHOURY of Haifa who was one of the first to arrive in Beirut, devoted a great deal of his time and energy to this work. Later on Drs. WADIE NASR and CHAFIC HADDAD devoted almost the whole of their time to it. In the X-ray department, Dr. ZAHY HADDAD was doing the X-ray examinations at markedly reduced rates.

The In-patient Department

The total number of patients admitted and treated during the year amounted to 710. Of these, 432 were Lebanese, 138 Palestinian, 96 Syrian and 44 of diverse nationalities

One hundred and fifty were single males, 163 married males, 65 single females, 295 married females, 9 widowers and 28 widows.

Four hundred and twelve were surgical and surgical specialty cases, 115 gynecological, 132 obstetrical and 53 medical cases.

One hundred and eighty patients were first class, 220 second class, 215 third class and 95 fourth class.

During the year we were approached by the Palestine Relief Committee regarding the hospitalization of casualty cases that had to be taken care of, and we were only too glad to be able to offer our services in that direction and we agreed to take them at reduced rates. The first installment arrived on the 5th. of June 1948. This called for additional staff and space but we were able to accomodate them without difficulty.

REPORT OF THE WORK OF THE SURGICAL SERVICE

The following is an analysis of the 424 surgical cases classified according to diagnosis :

Infections :		rheumatic joints	9
acute abscess	6	tumors and cysts	3
subacute infections	1	Diseases of the spine :	
cellulitis	6	spondylitis	1
whitlow	1	fracture-dislocation	1
dermoid cyst	4	lumbago	1
snake bite	1	osteoporosis	1
Gangrene	5	Pott's disease	1
Burns	1	trauma to the spine	3
Wounds :		coccydynia	1
bleeding wounds	7	Diseases of the scalp :	
infected wounds	2	hematoma	1
gun-shot wounds	3	Diseases of the brain :	
Veins and Lymphatics :		hydrocephalus	1
phlebitis	1	hemiplegia	1
elephantiasis	1	concussion	5
Skin diseases :		tubercular meningitis	2
eczema etc.	4	Lips and jaw :	
carbuncle of the neck	1	harelip	1
ingrowing toe nail	2	Mouth and salivary glands :	
Fractures and dislocations :		salivary calculus	1
fractures	15	fibroma of Stenson's duct	1
dislocations	1	Eye and ear :	
Diseases of bones and joints :		hernia of the iris	1
osteo-myelitis	9	trachoma	1
suppurative arthritis	1	otitis media	1
coxalgia	1		

Nose and throat :		cholecystitis with	
deviated septum	1	cholelithiasis	14
acute sore throat	2	Pancreas :	
hypertrophied tonsils	14	cancer	2
adenoids	2	Spleen :	
Oesophagus :		splenic tumor	1
stenosis	1	intestinal obstruction	1
cancer	1	Rectum and anus :	
Larynx :		prolapse	1
cancer	1	fistula in ano	5
Lungs and pleura :		hoemorrhoids	4
pulmonary edema	1	proctitis	1
hydatid of the lung	1	ischio-rectal abscess	2
cancer of the lung	2	Hernia :	
pleuresy	2	inguinal	39
empyema	1	strangulated inguinal	1
hemothorax	1	femoral	1
mediastinal tumor	2	ventral	6
Goitre :		strangulated ventral	1
toxic	3	Kidneys and ureters :	
colloid	1	solitary kidney	1
nodular	3	congenital anomaly of ureter	1
Breast :		hydronephrosis	2
cancer	2	ptosis	1
Abdomen :		renal calculus	10
ascitis	1	ureteral calculus	8
peptic ulcer	8	perinephritis	1
cancer of the stomach	1	pyelitis	6
enteritis	3	tumor of the kidney	1
intestinal perforation	1	polycystic kidney	1
tumor of the colon	3	Bladder and prostate :	
abdominal malignancy	2	urinary fistula	2
ulcerative colitis	1	cystitis	1
foecal fistula	1	vesical calculus	1
Appendix :		tumor of the bladder	5
fulminating appendicitis		hypertrophy of neck of bladder	2
with abscess	4	prostatic abscess	1
perforated appendix	4	prostatic hypertrophy	12
acute appendicitis	9	Testicles and cords :	
subacute »	1	hydrocele	3
chronic »	20	hematocele	1
Liver and gall-bladder :		Penis and urethra :	
cancer of the liver	1	circumcision	1
papilloma of gall-bladder	1	gonorrhoea	3
		undiagnosed	5

Analysis of Palestinian Casualties

Gangrene	1	Fractures :	
Wounds :		simple	2
shrapnel	8	compound	12
gun-shot	10	mal united	3
Aneurism :		Miscellaneous :	
traumatic of the vertebral		Traumatic osteo-myelitis	8
artery	1	Injury of the spine	1
Nerve injury :		Foreign body in the eye	2
radial	1	Stenosis of the oesophagus	1
sciatic	2	Traumatic pleuresy	1
		Perforation of the small gut	1

We have had some cases during the year which are worth reporting for their scientific interest.



Hemangioma of the Urinary Bladder

A case report

by

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and

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The rarity of hemangioma of the urinary bladder led MARION³¹ to call it "the altogether exceptional tumor". KELLY and BUMAN²² reported the first case in 1851. BROCA reported the second case in 1909¹⁶ from an autopsy. GUYON¹ performed the first operation on vesical hemangioma in 1892. This case died on the operating table from hemorrhage. LANE²⁴ reported a successful operation in 1895 where his patient improved after operation. BERLINER⁴ was the first to diagnose the condition by cystoscopy (1902), confirm the diagnosis by operation and report his case cured. JUNGANO¹⁷ was the first to report a microscopic study of his case in 1907. SEGAL and FINK³⁹ made a study of the subject and collected 35 cases from the literature (1942). KHALE et AL¹⁸ reported another case in 1942. Since that date only one more case has been reported by KAPUR¹⁹.

Case report :

Case No. 354 N. G. Age 15 M.S. Admitted Feb. 20, '48.

Chief complaint hematuria for the last twelve years.

Previous history. This patient was admitted by the senior author 12 years ago to the A. U. B. Hospital under case No. 25724 on Dec. 8, '36. His chief complaint then was painless intermittent hematuria of 15 days duration. Fifteen days prior to his admission he suddenly developed a mild terminal hematuria which was not associated with any pain, fever or frequency. Three days later the hematuria became continuous and total. One week later an attack of retention lasting 24 hours (?) was relieved by catheterization and several blood clots were washed out from the bladder.

X-ray of the urinary tract proved negative.

Physical examination : the only positive findings were a palpable liver and a just palpable spleen.

Cystoscopy : Dec. 9, '36. Under general ether anaesthesia. Bladder capacity 200 c.c. There is a small mass violet red in colour, the size of a bean located at the dome of the bladder right beside the air bubble giving the look of a hemangioma.

Urinalysis : albumen, heavy trace ; sugar, negative ; acetone, strongly positive. Numerous RBC and 4 - 7 WBC/HPF.

Following cystoscopy the patient ran a high fever. After it had subsided he was discharged and instructed to come back one month later for the removal of the hemangioma.

The one month proved to be 12 years' long.

To-day he comes back with the same symptoms of intermittent hematuria which has become more severe and total a month ago.

An X-ray of the urinary tract again proved negative, and a cystoscopy confirmed the previous findings with the exception that the growth is now more extensive.

An operation was advised and accepted.

Urinalysis ; Albumen, heavy trace ; sugar, negative ; RBC. very numerous.

Blood. RBC. 4,300,000 ; WBC. 8,600 ; B. P. 160/60.

Operation. Under general ether inhalation anaesthesia a median, vertical, supra-pubic incision was made, exposing the bladder. The growth involved the whole thickness of the bladder-wall at the dome just at the reflection of the peritoneum. It filled an area 6cm. in diameter. The peritoneum was stripped from the dome of the bladder, and the tumor with a healthy margin of the bladder-wall was removed and the bladder closed up tight. There was very little bleeding. The wound was closed in layers over the bladder, and a drainage wick was left in the space of Retzius, and an indwelling urethral catheter was passed into the bladder.

The post-operative convalescence was uneventful, the suprapubic wound healed by primary intention and the patient was discharged on the eleventh post-operative day, able to pass clear urine freely, and with a fairly good bladder capacity.

One month after the patient left the hospital he went back to school and now he has no frequency. He is able to hold his urine all night and is actively participating in his athletics at school.

DISCUSSION

Pathology. Hemangiomata of the bladder are identical to those found elsewhere in the body.

The two types, the cavernous and the capillary are known to exist. Of the reported cases 17 were examined microscopically. Of these

14 were of the cavernous type, 2 of the capillary and one was called angio-sarcoma.

The bulk of the tumor, as a rule, is located in the muscularis of the bladder. It may grow towards the mucosa and invade it or towards the peritoneum and invade it. The submucosal type is the one that tends to bleed most and it is this that makes the patient seek early medical advice. On the other hand those that grow towards the peritoneum may grow to considerable size and produce very little symptoms before they invade the neighbouring structures and become very extensive and consequently inoperable.

Diagnosis depends upon :

1. SIGNS AND SYMPTOMS :

a. Hematuria. This is the cardinal symptom and is characterized by being painless and intermittent. All the reported cases with two exceptions^{22 42} came to treatment because of this symptom. It has no relation to the size of the tumor and is due to tiny ulcerations on the surface of the growth caused by the squeezing of the growth by the walls of the bladder during the act of micturition, hence the terminal type of hematuria. If the condition is left alone and the bleeding points heal spontaneously then the bleeding will be arrested only to start again as soon as new bleeding points develop.

Pain is an uncommon accompaniment of hematuria and when present is due either to cystitis or to the passage of blood-clots through the urethra.

b. Frequency of urination is rare. When it exists it is usually due to cystitis or to decreased bladder capacity.^{27 38.}

c. Incontinence was mentioned in two cases.^{17 38.}

d. Urinary retention is a rare complication and is due to obstruction of the urethra by a blood-clot or by the tumor mass.^{17 22.}

e. Anemia is unusual^{3 36} and although patients seek treatment long before this symptom has had time to develop, cases that died from hemorrhage are on record.^{1 20 25.}

f. Temperature and pulse. Variations in these depend upon the presence or absence of cystitis and the extent of the bleeding.

g. Presence of other hemangiomata in the body. Nevi and multiple hemangiomata may be associated with this condition.^{2 4 11 13 24 28 32.}

2. CYSTOSCOPY IS THE MOST IMPORTANT DIAGNOSTIC PROCEDURE.

Of the reported cases diagnosis by cystoscopy was made only in

9 instances ^{2 4 14 28 30 35 37 41 42}, but only two of these were confirmed by operation ^{4 44}. Of the other cases some were diagnosed after operation while others only after a histological study of the tissue was made.

Treatment. The treatment of choice is total excision with a margin of healthy bladder wall. It is always advisable to shell off the peritoneum from the dome of the bladder and remove the tumor extra-peritoneally. This will be impossible when the peritoneum is involved. Some reported success with fulguration of the tumor intra-urethrally^{8 28 41} This is advisable only in small tumors. It is risky and dangerous in large ones because of the danger of puncturing a large vessel and starting an uncontrollable bleeding. Some of the large tumors are inoperable especially when they invade adjacent tissues as the rectum.³⁸ Any attempt at dissection may start a fatal bleeding. BACHRACH² used adrenaline instillations in the bladder with good results. We would like to caution against this procedure as it may produce fatal cerebral anemia.

Prognosis. SEGAL and FINK tabulated 31 cases of vesical hemangioma. Three were diagnosed at autopsy ^{6 25 40} and 3 were untreated. ^{35 37 42} Fourteen were reported cured ^{3 4 5 8 11 13 16 22 27 28 32 41} and one was reported improved.²⁴ Three had a recurrence (one 12 months³⁸ and one 17 months,³⁸ the third is not given¹²). The first of these was primarily treated by fulguration and the other two by operation. All three were later treated again by fulguration with success.

Four died of hemorrhage ; one before any treatment was administered,²⁵ one from rectal bleeding,³⁸ one on the operating table⁴ and one after fulguration.²⁰

Only one malignancy was reported.¹⁷

If completely removed these tumors do not recur, but if incompletely excised they tend to grow locally. When treated adequately and early the prognosis as to life expectancy and bladder function is very favourable, whereas if left untreated or badly treated they may end fatally from hemorrhage ^{4 20 38 25}.

CONCLUSION

1. An additional case of hemangioma of the urinary bladder is reported.
2. The condition was diagnosed by cystoscopy 12 years before the patient came to operation.

3. The cardinal symptom was intermittent, painless hematuria which at first being terminal became later total.
4. The condition was treated by complete removal.
5. The period of convalescence after operation was only 11 days.
6. The results were very satisfactory. There is no frequency, nocturia, hematuria or any other complication.
7. As this paper was being prepared for publication the patient was asked to come for a check-up. He is in perfect health and has no symptoms referable to the urinary tract.

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Surgery of the Gall - Bladder

by

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Diseases of the gall-bladder come under the attention of the internist as well as the surgeon, and unless there be a close cooperation between the two, the patient will be the losing party.

The gall-bladder, like the appendix is a blind alley, having four currents of fluid communicating with it. Two with its wall; the systemic circulation and the lymphatic circulation, and two with its lumen; the bile, through the cystic duct; one current coming from the liver, the other going to the duodenum.

Any one of these currents may carry infection to the gall-bladder and once the invaders settle on or within the host, war is declared and a battle is fought. As these battles are repeated, the gall-bladder becomes weaker, more exhausted and less resistant and considerable changes take place in its walls. The resulting condition is called - Chronic Cholecystitis. During some of these invasions nature erects tomb-stones in memory of the fallen brave. These are called gall-stones. Sometimes whole armies are destroyed at one time and the field of battle is converted into a cemetery. This is Empyema of the gall-bladder. If war is allowed to continue and more weight is brought to bear on the already weakened walls of defence by outside blockade and inside pressure, the result will be either gangrene or rupture of the walls. This in brief is the story of gall-bladder disease and its complications.

The clinical course of cholecystitis may be divided into three stages :

1. The stage of infection preceding stone formation.
2. The stage of stone formation.

3. The terminal stage of complications : empyema, gangrene and perforation.

Of the fourteen cases of gall-bladder disease that were admitted to this hospital during the year, eleven came to operation. One was a case of papilloma of the gall-bladder. None of them was in the first stage of the disease. Three were in the second stage, and seven were well advanced into the third stage.

Analysis of the eleven cases

Nº	Case Nº	Sex	Age	Diagnosis	Days in hosp.	Result
1.	32	F. M.	47	Fibrosis with calculi	23	Cured
2.	120	F. M.	45	Fibrosis with calculi	10	Cured
3.	152	F. W.	50	Fibrosis with calculi	12	Cured
4.	204	F. W.	65	Papilloma with calculi	28	Cured
5.	209	M. M.	55	Perforation with calculi	2	Died
6.	411	F. M.	40	Gangrene with calculi	13	Cured
7.	419	M. S.	65	Perforation with calculi	4	Died
8.	444	F. M.	37	Empyema with calculi	28	Cured
9.	585	F. M.	48	Gangrene with calculi	41	Cured
10.	792	F. M.	40	Perforation with calculi	22	Cured
11.	862	F. M.	55	Perforation with calculi	11	Cured

It is interesting to note the high percentage of perforated cases in this series, 36 + %. If these be excluded the operative mortality rate will be nil. Of the cases that were perforated two died making the mortality rate 50 %.

We will give a summary of the perforated cases because they present many points of interest.

Case Nº 209 B. Ph. Age 55 M. M. Admitted Jan. 25, '48.

Chief complaint : abdominal pain and distension with dyspnoea of two days duration.

This patient was in this hospital once before (Dec. 17, '47) when he stayed 12 days and was treated for a bleeding peptic ulcer. The bleeding stopped. But he had clay coloured stools and a yellowish tint in his sclera. He was advised to be operated for his gastric condition and gall-bladder pathology but he refused to take our advice.

On Jan. 25 we saw him in consultation with his family physician who said that the patient was about his work since he left hospital although he was still having some abdominal discomfort. Two days ago he had an acute attack of abdominal pain. He passed some stools with an

enema but the next day the water of the enema returned clear and his abdominal distension got worse.

The following is his state on readmission :

T. 38.4° C. P. 130 R. 28 B. P. 120/80 WBC 14,000.

The patient is acutely ill. He has an anxious look and a yellowish tinged sclera. He is dyspnoëic, and his abdomen is markedly distended and tympanitic. It is rigid all over and is very tender in the R. U. Q.

The diagnosis of perforated peptic ulcer was made and an emergency operation was advised but was refused. The next morning his condition grew worse, a consultation was called and the family finally permitted us to operate.

The operation started under local infiltration anæsthesia with $1\frac{1}{2}\%$ novocaine was continued under ether. The abdomen was opened with a right paramedian incision and at once dirty bile stained fluid gushed out. It was impossible to explore the region of the pylorus and gall-bladder because of the mass of omentum which was filling the whole area. The size of the patient's abdomen and the thickness of its walls added to the difficulty. His condition was getting very bad so the operation had to be concluded. The fluid was emptied by suction, drainage established in both groins and in the gall-bladder region, and the abdomen closed.

The patient's condition grew rapidly worse after the operation and he passed away early the next morning.

The abdomen was inspected through the wound after death. The gall-bladder was found to be contracted and sclerosed, with an acute inflammation superimposed and a perforation in its dome which allows the tip of the index finger. A calculus was presenting at the crater of the perforation and another calculus behind it. The abdomen was full of the same kind of fluid which was obtained during operation. The peritoneal reaction was very extensive, and the large intestines were markedly distended.

Case No 419. T. P. Age 65. M. S. Admitted April I, '48.

Chief complaint : acute abdominal pain of three days duration.

For the past three days the patient has been having attacks of acute abdominal pain and colic which the physician called renal colic and put him under morphine and atropine. Last night, however, the pain got worse and a consultation was held at the patient's home at mid-night. T. 39° C. P. 120 R. 30. The abdomen was markedly distended and tender. The diagnosis of acute abdomen was made and an emergency operation was advised. After considerable delay the patient was removed to the hospital and at his physician's request an X-ray of the urinary tract was taken and proved negative. The patient was carried to the operating room.

The operation was done under ether anæsthesia. A Battle incision was made on the right side and as soon as the abdomen was opened dirty

bile-stained fluid gushed from the wound. The incision was extended upwards, and the gall-bladder was found to be badly inflamed and perforated. A cholecystectomy was made and the fluid aspirated. Both groins were drained as well as the gall-bladder region and the wound closed. The peritoneal reaction was very extensive and the gall-bladder contained a calculus the size of a pea.

Soon after the operation the patient was put on extensive doses of penicillin and streptomycin.

The next day the patient's condition grew steadily worse, he became delirious. On the following day he went into shock from which he never recovered. He passed away on April 5.

Case No 792 M. F. Age 40 F. M. Admitted Sept. 21, '48.

Chief complaint : abdominal pain of five days duration with high fever.

Five days ago the patient had an attack of pain in the R. U. Q. with fever but no vomiting. She had consulted us the previous day. We made the diagnosis of fulminating gall-bladder and advised her to enter the hospital for operation but she refused to take our advice and went back home.

The next day she came back with an acute abdomen.

T. 40.5° C. P. 150 B. P. 130/90 WBC 11,000. The abdomen is rigid and tender especially over the R. U. Q. The diagnosis of perforated gall-bladder was made and the patient was taken to the operating room at once.

The operation was done under ether. A right paramedian incision was made, and as soon as the abdomen was opened greenish purulent fluid gushed out from the region of the gall-bladder. The gall-bladder was perforated at its dome, the crater large enough to admit the tip of the index finger. The wall was thickened, gangrenous and markedly adherent to the liver. It was dissected away and there was some bleeding which was easily controlled. The peritoneal reaction was quite marked. A cigarette drain was left in the upper edge of the wound and the abdomen was closed in layers. There were five calculi in the gall-bladder.

The postoperative course was very stormy. The wound discharged bile and pus for several days. The patient was getting penicillin and streptomycin all the time after the operation. She was discharged on the 21st. day after operation and the wound was still discharging a little.

Case No 862 B. E. Age 55 F. M. Admitted Oct. 22, '48.

Chief complaint : acute abdominal pain specially over the R. U. Q. of two days duration. The patient had not eaten anything for two days but she vomited several times a sour yellowish vomitus. She had not had a bowel movement for two days.

T. 38.7° C. P. 128 R. 20 B. P. 140/90 WBC 18,450.

A pale looking woman with a subicteric hue in her sclera. Her abdomen is rigid specially over the R. U. Q. The diagnosis of acute cholecystitis with probable perforation was made and an immediate operation was advised and accepted.

The operation was done under ether. A right paramedian incision was made and as soon as the abdomen was opened bile-stained fluid escaped through the wound. The gall-bladder was gangrenous and had given way at a very small point through which bile was escaping. The gall-bladder was removed and the abdomen was drained and the wound closed in layers. Several calculi were found in the gall-bladder.

This patient's postoperative course was uneventful. She was discharged on the 11th. day after operation.

DISCUSSION

Perforation or rupture of the gall-bladder is of two types : traumatic and pathological, the latter being the more frequent. CHOYCE in his *System of Surgery* (Vol. II p. 796) places these cases under the title "Some rarer conditions". He says : *Acute perforation of the gall-bladder usually occurs in cases in which the gall-bladder is diseased, but in any event is rare. It was only met with 10 times among 1,000 cases operated upon for gall-bladder at the Leeds infirmary.*

A review of the English literature for the last ten years shows that pathological perforation ranges between 10 and 12 % of all operated cases of gall-bladder. In our series, although a very small one, the frequency of perforation was as high as 36+%. A. BLAIN and H. HARKIN (Surg. 21,110-135, Jan. 1947) could collect only 41 cases of perforated gall-bladder from the surgical reports of JOHNS HOPKINS Hospital for the years 1920 - 1947. Less than 1.6 patients per year.

Perforation occurs in one of four directions :

1. Towards the liver, resulting in pericholecystitis.
2. Into preformed adhesions around the gall-bladder - these being the result of previous attacks of cholecystitis.
3. Into a viscus to which the gall-bladder had adhered during previous attacks.
4. Into the free peritoneal cavity. This is the most dangerous in that it precipitates a generalized peritonitis which usually ends fatally.

All four of our cases had perforated into the free peritoneal cavity. At the time of operation every one of them had a marked peritoneal reaction worse in some than in others. In the first two the operation was too long delayed and the peritonitis was so extensive that it was impossible to save them. In the last two, the operation was done within 24 hours of the perforation, and it saved their lives.

This condition does not allow for any procrastination. The general practitioner as well as the general public must be educated to the fact that any attack of biliary colic lasting more than two hours requires surgical interference. The prevailing idea that there is no such thing as an emergency gall-bladder operation and that the patient should be held until the acute attack has subsided is false. In some of the early cases this waiting may not do much harm, but in the third-stage cases, delaying a necessary procedure will only allow the general condition to get worse. Where gangrene has set in, the process will not stop and the only inevitable result will be perforation.



Traumatic Aneurism of the Vertebral Artery

by

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Traumatic or false aneurism differs from true aneurism in the fact that its wall is formed by fibrous tissue, while that of true aneurism is formed by the vessel wall. As its name implies it almost always follows an injury. The blood from the wounded artery remains fluid and excites the tissues to the formation of a fibrous wall about it, producing a fibrous sac in communication with the lumen of the artery. None of the coats of the artery are present in the wall of the sac, as a rule it occurs in the neck and extremities rather than in the body cavities where a wounded artery is most liable to cause death from hoemorrhage.

The size of the swelling depends upon the blood vessel injured. It is apt to be large when it is in relation with a large blood vessel which is surrounded by loose subcutaneous tissue, and small when it is in relation with a vessel at a distance from the heart and is surrounded by tense fibrous tissue or an aponeurosis.

Of all the arteries that may suffer such injury the cervical portion of the vertebral artery is one of the least common. This is because it is deeply seated, well protected and out of danger's reach, and should an injury befall the neck it is more likely to end fatally from bleeding or from injury to the vital organs before there is time for an aneurism to develop.

The aneurism may be in the first (extra-spinous) or in the second (intra-spinous) portion of the artery.

On reviewing the literature on the subject we find that HEIFETZ² has already made an exhaustive study of it in an article which appeared in the *Annals of Surgery*. Vol. 122, pages 102-110.

We herewith give in a tabular form the cases mentioned in HEIFETZ Article.

TABLE

No. of cases	Author	Site	Diagnosis, how and when made	Results Remarks
20	Reviewed by MATTAS ³ 1893	Not given	not given	6 survived operation
60	Reviewed by PERRIG ⁴ 1932	6 - 1 st portion	»	28 died as a results of the lesion or following treatment.
		8 - 1 st portion probably	»	19 cured
		28 - 2 nd portion clearly or probably	»	1 improved
			»	1 recurred
		18 - site not reported	»	11 outcome not indicated. History of trauma is not given in 8 cases while in 4 other cases the author failed to indicate if trauma was a factor (2).
1	GIGLIO ⁵	2 nd portion	»	Cured
1	DRÜGG and SIEGMUND ⁶	»	»	Died from post-operative infection.
1	BARRAND ⁷	»	Diagnosed at autopsy	
1	OGILVIE ⁸	»		Not recorded
1	MEURER ⁹	»	Arterio-graphy	Cured
1	SPATH ¹⁰	»		Cured
1	HEIFETZ ²	1 st portion	at operation	Cured

From this review it will be seen that aside from the six cases which are definitely those of traumatic aneurism of the second portion it is impossible to tell how many others are of the same site.

The extreme rarity of this condition, therefore, warrants the report of the following case which is one of the suboccipital portion of the artery.

Case report :

Case No 599. K.L., F.W., Age 73 years. Admitted on 22nd June 1948 with the chief complaint of pain in the neck and head of one month's

duration. A month before admission the patient received a bullet below the lower right lid which pierced the maxillary bone and did not leave the body. She vomited much blood which was pouring in the mouth from an undetermined origin. Since then the pain localized in the left side of the neck especially behind the left ear. Pain is incapacitating and is associated with a distressing tinnitus, to an extent that the patient complains of being unable to lie down, but has to hold her head between her hands.

Physical examination reveals an intelligent old female with a scar below the lateral canthus of the right eye caused by the entrance of the bullet and producing a lagophthalmos.

In the neck just behind the left ear and over the mastoid process, there is a small pulsating swelling the size of a hen's egg. Auscultation over the mass gives a systolic thrill. Pressure over it does not produce any change in the pulse, and digi-pressure over the carotid did not affect the pulsation in the mass, nor did it cause any diminution in its size.

The heart is not enlarged, heart sounds normal, blood pressure is 120/70^{mm} of Hg.



An X-Ray of the skull revealed a bullet lodged over the 1st cervical vertebra on the left side.

The tentative diagnosis of aneurism of the vertebral artery was made and of the occipital artery to be excluded.

On June 23rd 1948, under general ether inhalation anesthesia, an oblique incision was made at the anterior border of the left sternocleidomastoid muscle, the carotid sheath was opened and the common carotid compressed temporarily for about five minutes with the fingers. This did not affect the pulsations in the tumor or its size. The occipital artery was similarly treated without any effect on the tumor. The vertebral artery was then exposed at its 1st. portion and compressed, the aneurism decreased in size and stopped pulsating, the artery was released, the pulsations came back, the vertebral artery was ligated and the wound closed in layers.

Two days following the operation patient was much improved « being able to lay her head down on the pillow and go to sleep ». The tumor got smaller in size and the pulsations have almost completely disappeared.

The post operative course was very calm, the stitches were removed on the 7th post operative day.

On July 8th 1948 the patient was discharged walking. The swelling had completely disappeared and there was no more pulsation felt in the region under the occiput.

DISCUSSION

1. **Etiology.** The artery is wounded either by a sharp weapon, a missile or a fractured piece of transverse process of the cervical vertebra. The causative agent in our case was a missile (cf-fig.)

2. **Symptomatology.** Symptoms may be due to the pulsation of the mass which causes throbbing pain at the site and tinnitus or those due to pressure producing pain or / and paralysis.

Our patient suffered from excruciating pain in the head, and very severe tinnitus. Her neck was stiff and she could not keep her head down on the pillow. Her head was always between her hands.

3. **Diagnosis.** The diagnosis of the aneurism itself is not difficult to make. The pulsating mass which gives a thrill on auscultation helps to make a diagnosis. But it is not always easy to define the vessel to which the aneurism is attached. As evidence of this difficulty we would state that the carotid artery has been ligated in well over half of the reported cases of aneurisms of the vertebral artery². This is a dangerous procedure as it shunts the circulation to the area supplied by the affected vertebral artery and thus increases the load carried by it. We were lucky not to have fallen into the same trap and have applied digital pressure on the carotid and the occipital to exclude them from the picture before we finally ligatured the vertebral.

4. **Treatment.**⁴¹ This largely depends upon the site of the injury (the ideal treatment in anyway would be the removal of the aneurism and the least possible interference with the circulation⁴²). The ligation of the vessel on both sides of the aneurism and the emptying of the blood clot practised by ANTILLUS in the 3rd. century cannot be applied in many cases of vertebral aneurisms especially of the intra-spinous portion for obvious reasons. (The anatomical disposition of the artery itself and the difficulty of approach to its sub-occipital end). The HUNTER operation which consists of ligating the artery on the proximal side of the aneurism, is the operation we performed in our case and it has given us an excellent result. It has not been successful in the case reported by HEIFETZ who had to resort to another method of treatment. Of course, his case was of the extra-spinous portion of the artery and proximal ligation may have been very difficult. The method which he employed the second time was that suggested by KUTTNER⁴³ who utilizes a muscle transplant with which he tampons the aneurismal sac. This method of muscle tampon has been described by McNEALY & SHAPIRO⁴⁴. They demonstrated experimentally, that muscle transplants adhere to the intima by the development of a proliferative endarteritis and that recanalization does not occur.

The ideal treatment is the reconstructive endo-aneurismorrhaphy of MATTAS⁴⁵. This procedure is very difficult if not impossible in cases of aneurism of the vertebral artery because of its anatomical disposition.

CONCLUSION

1. The literature on traumatic aneurism of the vertebral artery is reviewed.
2. The condition is extremely rare and justifies the reporting of a case of the suboccipital portion of the artery.
3. Ligation of the artery in its first portion brought about a complete cure in our case.
4. Other lines of treatment are discussed.

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Hydatid Disease of the Lungs

by

SAMI I. HADDAD, M.D., F.A.C.S.

In a previous communication on 'Hydatid Disease in Syria' we remarked that 'the distribution of the disease in the different parts of the body is similar in Syria to that in other countries'. Recent observations, however, show that hydatid of the lungs is more frequent in Syria than in other countries. The usual percentage given is 20, but we have noticed that it is much more frequent than this.

A very significant feature of pulmonary hydatid is that it often occurs in both lungs simultaneously, and that it is frequently multiple in one or in both lungs.

Sometimes one cyst attains large dimensions, at other times all the cysts may be of equal size.

The location of the cyst is of great importance to the surgeon when surgical intervention is contemplated.

Small cysts and those centrally located are very difficult to reach with the knife, and the best line of treatment for these cases, we think, is the expectant treatment. Cysts which grow near a bronchus may rupture into it and will be expectorated in time. This expectant treatment, however, is associated with the danger of recurrence if small shreds of the membrane are retained in the lung cavity, or of infection of the cyst cavity.

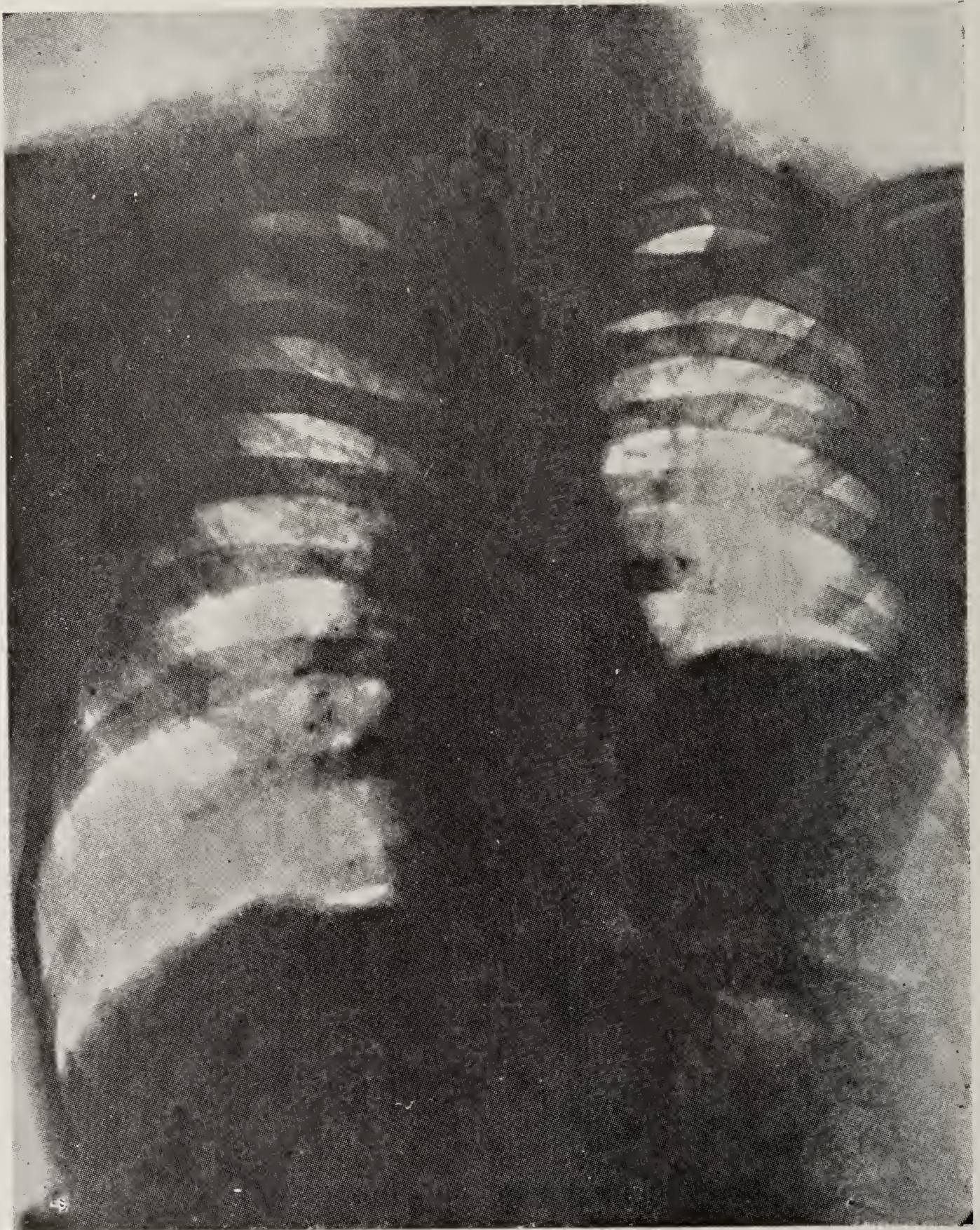
Large cysts which grow towards the pleura lend themselves best to surgical treatment. We used to operate on these cases in two stages but now we feel that it would be better if the entire cyst could be removed in one sitting.

The following is an illustrative case :

Case No. 58 G.M., Age 32, M.M., Admitted Nov. 11, '47.

Chief complaint : recurrent stitch in the left side of the chest with mild pain of three months duration.

Physical examination revealed dulness over the lower half of the left chest, the dulness being in the postero-lateral region. A friction rub was heard over the area of dulness. A soft, short systolic murmur suggesting a thrill was heard over the apex of the heart (from the cyst ?). B.P. 140 80.



The X-ray showed a large rounded shadow in the base of the left lung near the periphery.

Diagnosis : hydatid cyst of the base of the left lung.

The patient was advised to be operated and he accepted the advice.

The operation was performed on Nov. 12, '47.

Under local infiltration anaesthesia of novocaine 1/2 %, a hockey-stick incision was made over the base of the left lung extending upwards and towards the vertebral column. Long segments of the 7th., 8th. and 9th. ribs were resected from the postero-lateral side of the chest. The intercostal muscles were removed over that area. The parietal pleura was sutured to the visceral pleura with a circular suture of chromic cat-gut N^o. I. An incision 5cm. long was made through the cyst. The fluid was evacuated at once with the aspirator and the chitinous membrane was extracted with a sponge forceps. The cavity was drained and the wound closed.

The patient made an excellent recovery. The highest temperature recorded was 38.5°C. On the eighth day it came down to normal and remained normal. He was discharged on Nov. 26 in excellent condition. On Dec. 12 he was back to work.

DISCUSSION

The secret of the success of this operation is the immediate evacuation of the fluid from the cyst as soon as it is opened. Failing this, the fluid will be inspired into the lungs and will cause a very severe anaphylactic reaction which may be fatal. The chitinous membrane should be pulled out with great care in order not to allow any piece of it to get torn and remain inside the cavity.

If these cases be handled gently there is, as a rule, very little bleeding and the reaction will be negligible.

CONCLUSION

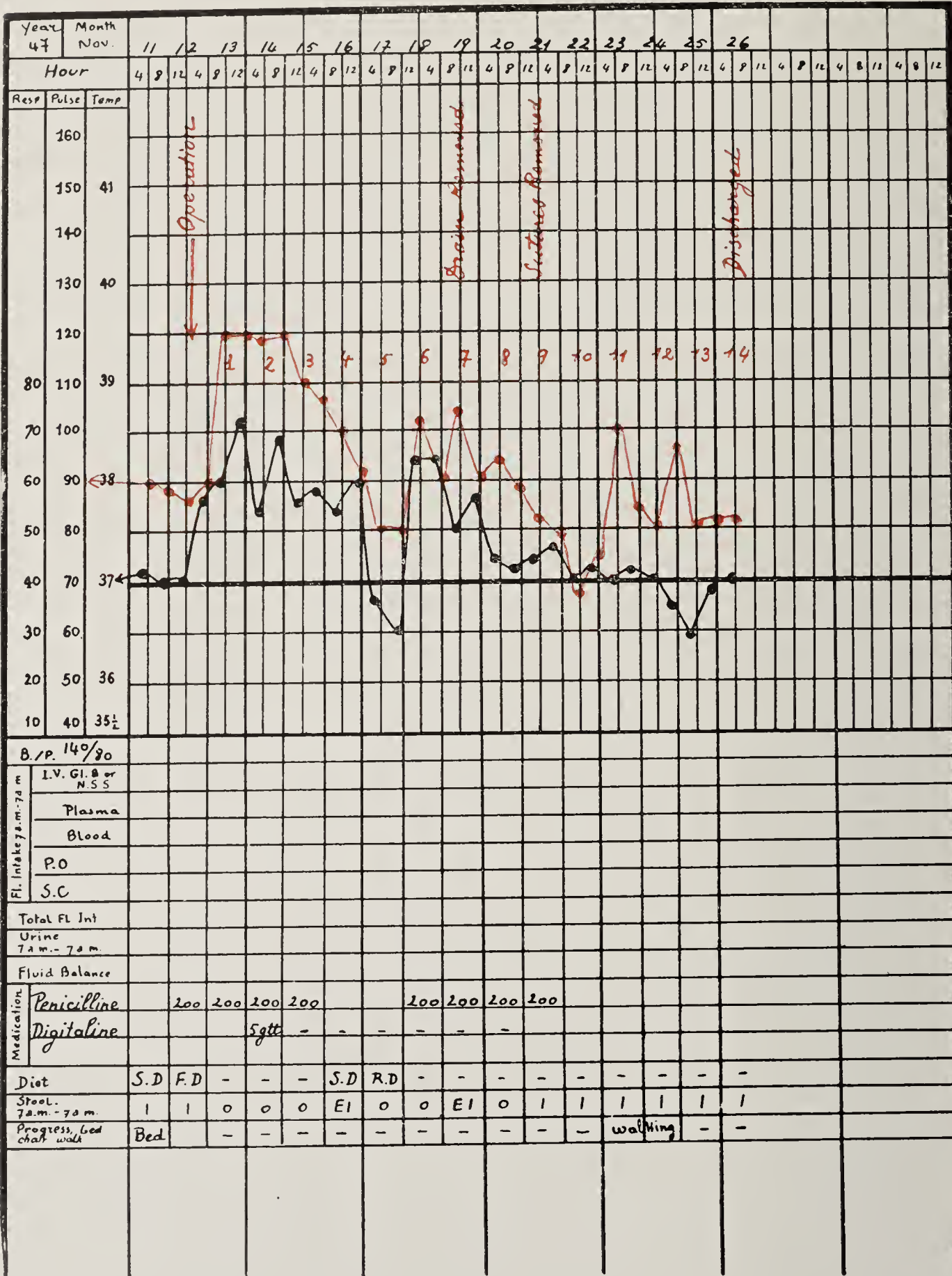
1. The incidence of hydatid disease of the lungs is more frequent than it was supposed to be.
2. The significant feature of its occurrence in both lungs simultaneously and its multiplicity in one or both lungs has been remarked.
3. Some cysts are located so deeply in the lung that it is wiser to handle them expectantly.
4. Cysts that grow towards the periphery are best treated surgically and in one stage.
5. The best anæsthetic is local infiltration with novocaine.
6. The one stage operation is described.

TEMPERATURE CHART

Case No. 58

Name: G. M

Bed No. 9C. D: Sami Haddad



7. The greatest danger in these cases is anaphylactic shock which is caused by the rapid inhalation and absorption of the liberated fluid from the cyst, hence the importance of opening the cyst with a large incision and aspirating the fluid at once.

8. If long segments of the ribs be removed the cavity will collapse in a very short time, and the period of invalidity will be considerably shortened.

9. Lobectomy for hydatid disease of the lung is coming into vogue of late but it remains to be seen whether the results obtained with this procedure will prove superior to those obtained by the other less drastic methods of treatment. Let us hope that the remedy will not be worse than the disease.

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Report of the Work of the Service of Gynecology and Obstetrics

by
MUSTAFA M. KHALIDY, M. D.

The service of gynecology and obstetrics took care of 247 patients during the year. Of these 115 were gynecological cases and 132 were obstetrical. Following is the analysis of these cases :

GYNECOLOGICAL CASES

Abortions	16	Pregnancy, early	7
Anteflexion	1	ectopic	7
Cervicitis with lacerations	3	Prolapse of the uterus	5
Endo-cervicitis	1	Pyometra	1
Cystitis	1	Retained placental mole	4
Cystocele	1	Retroversion	3
Fibrosis uteri	2	Salpingitis, chronic	2
Fistula (vesico-vaginal)	1	acute	5
Hematosalpinx	1	Sterility	11
Hydrosalpinx	2	Tumors, cancer of the uterus	2
Hypertrophy of the labia majora	1	cancer of the cervix	1
Hyperemesis gravidarum	1	cancer of the tube	1
Menorrhagia	1	Epithelioma of the vulva	1
Occlusion of the tubes	2	Fibroma of the uterus	20
Pelvic inflammation, abscess	3	Ovarian cysts	5
peritonitis	1	Sclerosis of the ovary	1
tuberculosis	1		

OBSTETRICAL CASES

Deliveries, normal parturition	93	Pre-eclampsia	1
forceps	8	Eclampsia	1
caesarian section	11	Post-partum hemorrhage	3
twin delivery	2	Premature labour	2
Rupture of the uterus, hysterectomy	2	Still-births	5
Placenta previa	4		

It is worthy of note that there were no mortalities among the patients in the service of gynecology and obstetrics.

As a general rule we kept uncomplicated abdomino-pelvic cases in the hospital 12 days, and we have encouraged them to get out of bed early whenever their condition allowed. Of all the operated cases referred to in this report not one developed pelvic or femoral thrombo-phlebitis.

Spontaneous Rupture of the Uterus with a report of two Cases

by
MUSTAFA M. KHALIDY, M.D.

Rupture of the uterus may occur during early and late pregnancy and during labour. It is either traumatic or spontaneous.

As a rule traumatic rupture occurs during the early months of pregnancy and usually is due to an attempt at abortion or other forms of instrumentation, the wall of the uterus being perforated by a curette, catheter or any other form of instrument or foreign body introduced into it.

Spontaneous rupture never occurs in early pregnancy. However, the syncytial cells of a hydatidiform mole may sometimes perforate the uterus in several places.

In late pregnancy rupture of the uterus is more of the spontaneous type, when it is caused by a previously weakened uterine wall or an anomaly of the uterus. The scar of a previous caesarian is the most common occasion for rupture. Less common causes are scars of old curette perforations or of scars of myomectomy wounds, also thinning and fibrosis of the uterus from adherent placenta or placenta accreta of previous pregnancies.

Pregnancy in one horn of a double uterus, uterus septus and congenital hypoplasia of the uterine wall are among the congenital anomalies which predispose to rupture of the uterus. In this type of rupture the injury is almost always in the upper portion of the uterus where all its layers will be torn.

Rupture during labour is a more common finding, it is also here either spontaneous or traumatic. Spontaneous rupture may be due to separation of scars of the uterine wall caused by a previous cesarean section, myomectomy, and placenta accreta, or to overstretching of the lower uterine segment in transverse presentation, contracted pelvis, pelvic tumors and other causes of dystocia. Congenital defects as double uterus also could be a cause.

Traumatic rupture may be produced by rough and unskilled attempts at operative delivery. Perforation of the uterus with a forceps blade could also occur.

Rupture of the uterus is more common in multipara, the ratio being 2 : 1.

During the year we have had two cases of spontaneous rupture of the uterus during labour which we are reporting for their scientific interest.

Case reports :

Case No 565 S. S. age 43. Admitted June 7, '48.

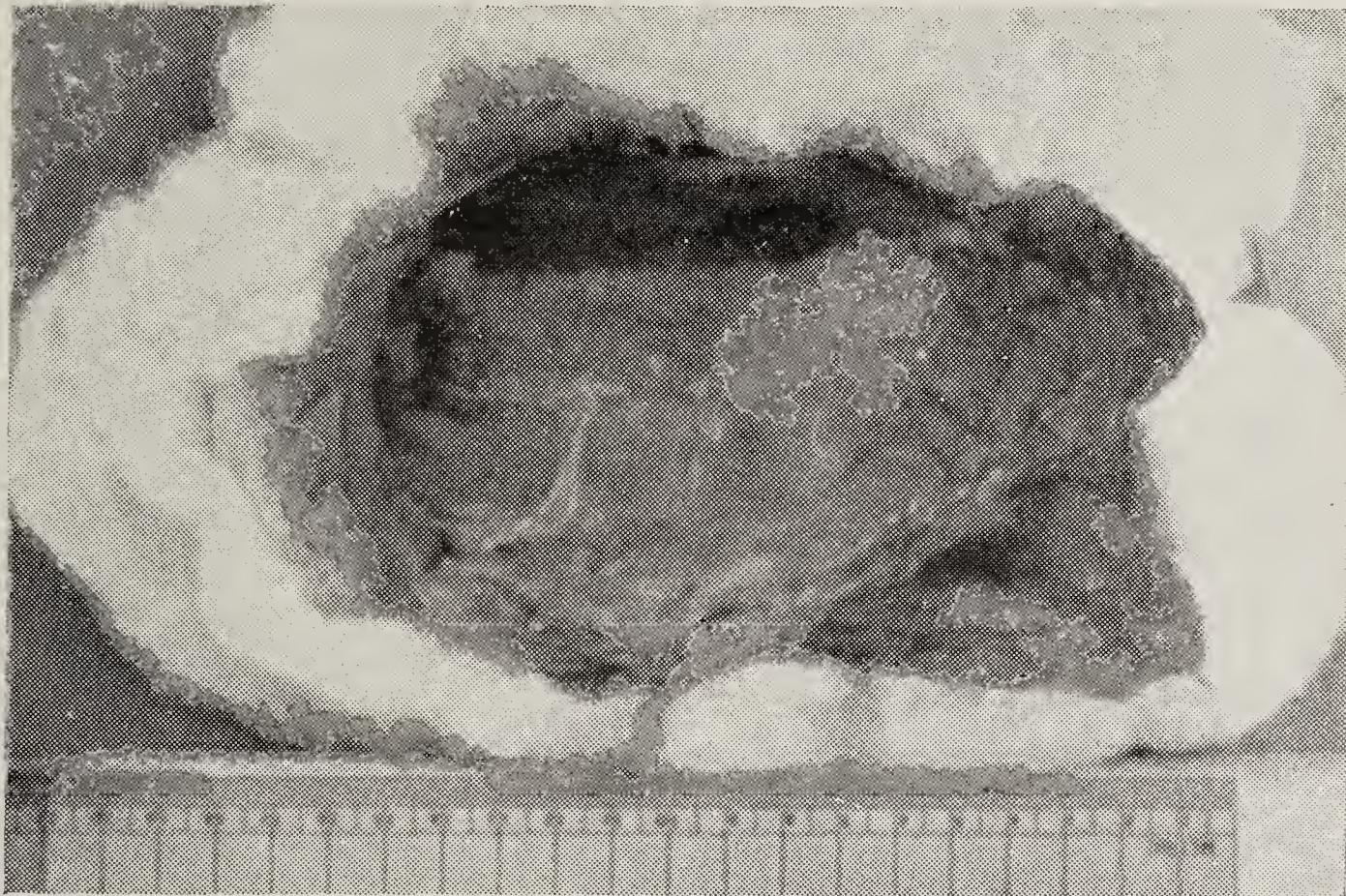
A full term pregnant woman, complaining of abdominal distress but no pains. She had 19 pregnancies. Now she has 11 children living and well. There is no history of dystocia. She did not receive antenatal care during her pregnancy.

On admission she was found to have a large hydramnios which was assumed to be the cause of her distress. She was put to bed under observation and was made comfortable. Two days after admission, the patient started labour by first rupturing the membranes and simultaneously began to complain of severe abdominal pain in the right lower quadrant; she lost a large amount of fluid and fifteen minutes later a living baby girl was born spontaneously weighing 3.5 kgs., and the patient collapsed immediately. The pain on the right side continued to be felt by the patient, and the spot was very tender on palpation. Slight and persistent bleeding continued in spite of oxytocics and a contracted uterus. The external bleeding was not considered adequate explanation for the shock and circulatory collapse, and the diagnosis of rupture of the uterus with severe internal bleeding was made. The patient was given 500 c.c. of blood intravenously before an exploratory laparotomy was performed.

Under general ether anaesthesia the abdomen was opened and about two litres of blood were found free in the peritoneal cavity. The uterus was found to be contracted with a twelve centimeter tear in the right side involving the area of the lower uterine segment. A supravaginal hysterectomy was completed. The patient had a moderate febrile postoperative course and was discharged on the twelfth day with her baby in good condition.

Case No 621 S. F. Age 29. Admitted to the hospital June 30th, '48 in labour. The patient is a primipara who was treated one year ago for sterility and a large solitary myoma was removed by an abdomino-pelvic operation. No antenatal care was given to her during her pregnancy, and when she came in, she was already several hours in labour, breech presentation

Inspite of strong pains, dilatation was progressing very slowly and after 36 hours dilatation was incomplete and the patient very much exhausted. Caesarian section was contemplated, and under general ether inhalation anæsthesia, the abdomen was opened and the uterus was found to be studded with small fibromyomatous nodules all over its surface, and at the site of the old myomectomy scar, the uterus had given way and portion of the membrane was bulging out.



The damaged condition of the uterus and the threatened complete rupture made one feel that future pregnancy is very hazardous and consequently PORRO's operation was performed. A normal living baby girl weighing four Kgs. was delivered. Postoperative convalescence was uneventful and both mother and child were discharged on the 12th. day postoperative in good condition.

CONCLUSION

1. Out of 132 obstetrical cases we had 2 cases of rupture of uterus, thus making 1.5 %.
2. Both patients had spontaneous rupture of the uterus and during labour.
3. The probable cause of rupture in the first case was the weakening of the uterine muscles which reached its maximum on the 20th pregnancy. Blood transfusion was life saving to her.
4. The rupture of uterus in the 2nd case was the site of an old myomectomy scar.
5. Both patients had hysterectomy and both discharged on the 12th day post operative.

Ectopic Pregnancy

by
MUSTAFA M. KHALIDY, M. D.
and
ALI F. ATAWNEH, M. D.

Ectopic pregnancy, eueyesis or extra-uterine pregnancy means a gestation which occurs outside the cavity of the uterus. The most common sites of the resting of the ovum ; the median or isthmial, the ampullary and the uterine or interstitial portion of the tube, the ovary and the cervix respectively. It could also be abdominal as on the posterior fold of the broadligament and on the omentum, although this last is extremely rare. Double tubal gestation has been observed, also two gestation sacs in one tube. WEYENTH has reported 71 cases of bilateral ectopic pregnancy. They occur most often in women after the age of 30, frequently after a long period of relative sterility, and in women who have had a previous pelvic disease. If extra and intra-uterine pregnancies coincide, prognosis is usually bad. Abortion of the uterine ovum precedes or follows the rupture of the ectopic sac, but death from internal hemorrhage may occur before abortion takes place. If the ectopic pregnancy is successfully removed, the intra-uterine one may progress to term normally.

Salpingitis (especially gonorrhœal), pelvic adhesions, infantile tubes, excessively long tubes, diverticula and accessory tubes, spasm of the tube, muscular insufficiency and anti-peristalsis, have been mentioned as possible causes of ectopic gestation. J. M. FRANKEL and S. B. SCHENCH supported the theory that endometriosis of the tube, ovary or cul-de-sac could be causes also. Changes in the uterus, in response to stimuli of pregnancy takes place. The uterus hypertrophies but not as much as if it were carrying the ovum itself and it exhibits intermittent contractions. A decidua develops in it and it presents all the characters of a decidua of an intra-uterine pregnancy except that it contains no chorionic villi. At the time of the abortion or labour, the decidua is cast off in one piece as a cast of the uterine cavity or in large shreds or plaques.

Of the 7 cases of ectopic gestation we have had during this year one was a recurrence ; because of the special features of interest we report this case :

Case No 256 J. K. H. Age 27 F. M. Admitted Jan. 5, '48.

Chief complaint : pain in the right lower quadrant of 9 hours duration.

Patient started to have pain in the R. L. Q. all at a sudden without any prodromal symptom. She was nauseated and vomited. There was no vaginal discharge, no history of abortion nor has she missed any period. She has had a left salpingectomy 2 years ago for left ectopic gestation. She has 4 children all in good health. Patient is not in shock. T. 37.5° C. R. 18 P. 85. B. P. 110/70. WBC. 13,400, abdomen tender in R.L.Q., with slight rigidity. Vaginal examination : tenderness in the right fornix, but no definite mass felt. Rectal examination revealed tenderness in R. L. Q.

Operation done on the same day. Begun with local infiltration of novocaine and continued under ether. A Battle incision was made on the right side. Free blood was found in the peritoneal cavity, the tubal pregnancy was delivered through the wound and a salpingectomy made. The abdomen was closed without drainage.

The patient made an uneventful recovery and was discharged on the eleventh postoperative day.

DISCUSSION

DELEE and GREENHILL state that repeated extra-uterine pregnancies after months or years are observed in about 4 % of cases of ectopic pregnancy. The recurrence may be in the stump of the original tube or in the other tube.

GOODRICH C. SCHAUFFLER and FREDERICK O. WYNE reported 65 cases of ectopic without a recurrence in any of them, and ascribe the cause to sterilization of the patient or to the occurrence of pelvic infection.

Clinical course and symptoms. The usual story is that the patient misses a period and has the ordinary symptoms of early pregnancy. Without any warning the ectopic may rupture and the patient will feel a sudden pain on the affected side, which will soon spread all over the abdomen and is sometimes associated with nausea, vomiting, diarrhoea, the symptoms of hemorrhage and shock. The patient becomes dizzy with a small rapid pulse, pallor and low blood pressure. A piece of decidua may be discharged. The first hemorrhage is rarely fatal, but a few weeks later if the clot be discharged or if there is high blood-pressure, hemorrhage is repeated and it might be fatal.

Diagnosis of ectopic gestation before rupture of the tube or hemorrhage into it is rarely made, because the tube is as soft as an intestinal loop and cannot be felt on physical examination. IRVING F. STEIN reported that gynecography could be beneficially employed in the diagnosis

of early and unruptured ectopic pregnancy and stated at the same time that trans-abdominal pneumo-peritoneum was good for diagnosis and was less harmful and more informative than hystero-salpingography.

In differential diagnosis, abortion, intra-uterine angular pregnancy, pregnancy in retroflexed uterus, twisted ovarian cyst, twisted hemato-, hydro- or pyosalpinx and last but not least, appendicitis, should be taken into consideration.

In all of our cases where we have suspected an ectopic gestation, we have been doing a harmless, simple and almost always instructive procedure - that is puncture of the cul-de-sac. This is done in the following way : After having prepared for a possible laparotomy, the patient is placed in the lithotomy position, a thick aspirating needle is pushed into the cul-de-sac through the posterior vaginal fornix. If pus is aspirated it is most likely a pelvic abscess and it is drained from below. If blood is obtained it is most likely a ruptured ectopic and an abdominal operation is performed.

GOODRICH C. SCHAUFFLER and FREDERICK O. WYNE in their report on 65 cases of ectopic gestation state that cul-de-sac puncture was the most reliable test and it gave conclusive results with them in 92 % of the cases in which it was used. As to FREIDMAN test, they conclude that a positive result was significant but it did not differentiate a disturbed intra-uterine pregnancy. A negative reaction does not exclude ectopic, but a negative reaction in a case which is not emergent is very helpful. DELEE and GREENHILL state that the test changes after rupture of the ectopic.

Treatment. If an unruptured ectopic is diagnosed, it should be removed, as it is like a chronically ill gall-bladder, a potential danger.

In cases of rupture with free bleeding into the abdominal cavity, operation for the removal of the mass is indicated immediately even if the patient is in shock, having plasma and whole blood given during and after operation. It is a good routine to inspect the other tube for possibility of a bilateral ectopic gestation.

In cases of old rupture and the formation of a hematoma or a hematocele, one may remove the blood by laparotomy, by vaginal incision or by drainage, or leave it to get absorbed. Absorption depends upon the size of the mass and may take four weeks to four months and some of them may suppurate.

The Story of the Caesarian Operation in Oriental Literature

AL-BÎRUNI an Arab physician and scholar, who lived in the 10th. Century. A. D. is the author of many books on medicine, history and astronomy. One of the most interesting of his books is the one entitled «Al-Athar ul-Baquia' an il-Qurun el-Khalia ». This book was edited by Professor SACHAU of Berlin. The manuscript which he used did not contain the 24 illuminated pictures which are found in the Edinburgh Manuscript. One of these pictures, the one which we reproduce here, shows the caesarian operation.



In the text, AL-BÎRUNI states that the mother of Caesar Augustus died in labour and her abdomen was cut open and the child delivered through the wound. He also mentions another instance where a certain AHMED IBN SAHL was delivered in a similar manner, but he does not mention that any other Caesarian operation occurred during his life time, although AL-FIRDAWSI, his contemporary, relates that RUSTOM the son of ZAL was delivered by a Caesarian operation performed on his mother RUDABA. In his «Shah Nama» which he wrote in Persian, AL-FIRDAWSI relates a very interesting story which goes to say how a bird sent from God appeared to ZAL and told him to secure an able physician who will drug RUDABA to sleep and with a sharp iron open her side, deliver the baby and suture the incision which when touched with a feather from his wing will recover immediately and thus will bring all their anxiety and sorrows to an end.

Whether this be a legend or is based on fact it is enough to show that the Orient was aware of the Caesarian operation which was used not only with the aim of getting a living baby but with the sincere hope of saving the mother's life as well.

Further research is very highly desirable to find out whether there is any more mention of this subject in the unedited Arabic Manuscripts or in any other Arabic literature.

THE EDITOR



The Department of Roentgenology and Electro-therapy

by

ZAH I. HADDAD, M. B. E., M. D.



Ample X-ray facilities are provided for in the hospital. The Picker Century X-ray unit for diagnosis and superficial therapy occupies the east wing of the ground floor. This unit services the hospital, the out-patient department and out-side patients referred by private practitioners. A portable set the 'Heliosphere' services non-ambulatory patients in the hospital and patients in their homes. A third set, the Sanitas mobile unit is for use in the out-patient department and clinic.

The importance of the X-ray as a diagnostic unit is indisputable and its value cannot be fully emphasized. Of late it has become an integral part of a class 'A' hospital. In a large percentage of diseases unless the clinical diagnosis be confirmed by X-ray it is not considered complete and consequently adequate treatment cannot be administered. Moreover, X-ray examination is essential in many cases to elucidate the diagnosis, which otherwise, may remain obscure. As an illustration of this fact we may cite a case where the patient after complete recovery from appendicectomy developed high temperature. A subdiaphragmatic abscess was suspected and an X-ray film was taken. As the film was being processed the surgeon seeing air under the right leaf of the diaphragm rushed the patient to the operating room and removed 200 c.c. of pus from below the diaphragm giving the patient immediate relief and complete ultimate recovery.

Fractures and dislocations, infections and diseases of bones, spine and skull, diseases of the abdominal organs ; stomach, intestines, liver, gall-bladder, spleen and pancreas ; genito-urinary diseases, lung diseases and diseases of the brain are a few conditions where X-ray examination is of inestimable value for diagnosis.

Removal of foreign bodies ; bullets, pieces of shrapnel, coins, etc., and the setting of fractures are greatly facilitated by fluoroscopy where without it such operations are not only very difficult but at times impossible.

In the electrical department a short wave treatment machine, a diathermy, an ultra-violet and infra-red lamps and a galvanic and faradic current machines are available for diagnosis and treatment.

The First Annual Report of the Orient Hospital

PUBLISHED
BY
THE HOSPITAL BOARD OF DIRECTORS
BEIRUT - LEBANON

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